

# THE **CANADIAN HOSPITAL**

**OFFICIAL JOURNAL  
CANADIAN HOSPITAL COUNCIL**

**JANUARY, 1944**

# The DOCTORS' HOSPITAL

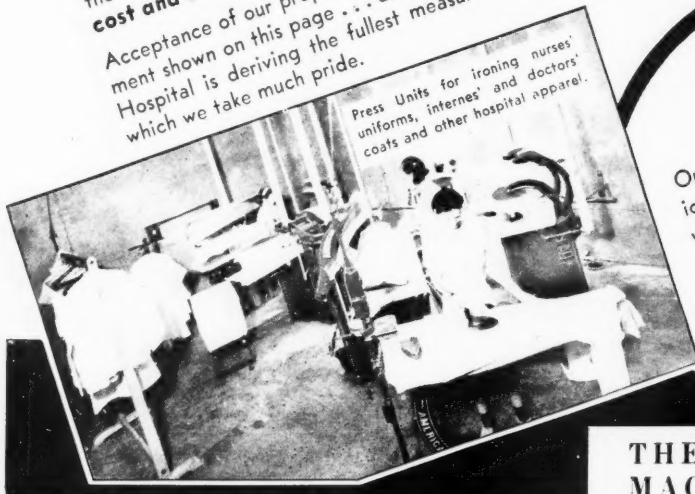
WASHINGTON, D. C.

## HAS AMERICAN-PLANNED-AND-EQUIPPED LAUNDRY

When plans for the Doctors' Hospital, Washington, D. C., were prepared, provision was made for a modern laundry department to service the 250-bed hospital's soiled linens.

Privileged to offer our Laundry Advisory Service, we made a thorough study of the hospital's laundering needs. A carefully planned layout of the proposed laundry equipment was then submitted. It provided for high production equipment of the correct size and capacity to launder soiled linens according to the hospital's exacting requirements—at lowest possible cost and on shortest schedule.

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Press Units for ironing nurses' uniforms, internes' and doctors' coats and other hospital apparel.



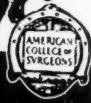
Washroom of American-equipped laundry at Doctors' Hospital, Wash., D. C. Fast washing, Monel metal, NORWOOD CASCADE Washers at right. Mechanical loading and unloading NOTRUX Extractor at left.



American STREAMLINE Flatwork Ironer which keeps Doctors' Hospital supplied with beautifully ironed sheets, pillow cases and other linens.

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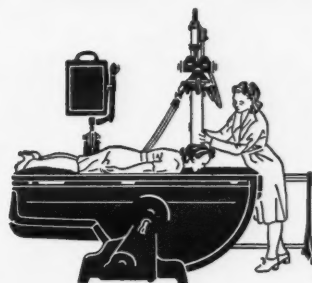
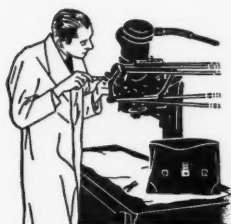
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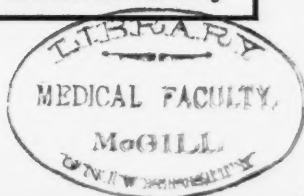
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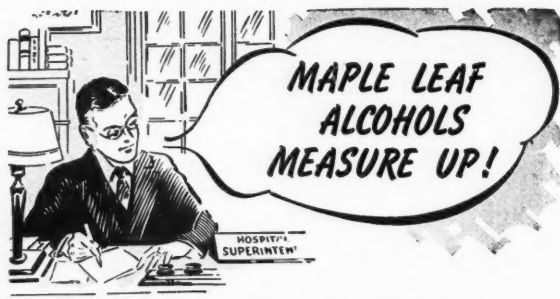
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Gelseals have been developed through a research organization that is unexcelled in its field, and represent a valuable contribution to medical practice. Many physicians think first of Gelseals when symptoms of vitamin deficiencies are presented. Every pharmacy should carry complete stocks.

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The CANADIAN HOSPITAL



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WAR INDUSTRY requires a colossal supply of manpower. Already a large percentage of it is provided by a working army of women.

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'Riona' Capsules can improve the efficiency of female workers by combating the physiologic "slow-down" periodically experienced by most normal women between the ages of fourteen and forty-five. 'Riona' Capsules

contain 'Propadrine' hydrochloride,  $\frac{3}{4}$  gr., acetophenetidin, 2 gr., and aspirin, 3 gr. In the treatment of dysmenorrhea, the analgesic effect of aspirin and acetophenetidin is aided by the antispasmodic action of 'Propadrine' hydrochloride on the myometrium.

'Riona' Capsules are also indicated for the symptomatic relief of headache, neuralgia, rhinitis and malaise associated with hay fever or the common cold. 'Riona' Capsules, individually wrapped in cellophane, are supplied in boxes of 100. Sharp & Dohme (Canada) Ltd., Toronto 5, Ontario.

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***Complete Kitchen Equipment***

No kitchen is too small, no kitchen too large for complete AGA equipment. We can supply all your needs. Steam tables, cast aluminum kettles and roasters, spun utensils, meat blocks, food and dish wagons, tea and coffee urns to your own specifications.

Let us estimate on your requirements.



We are sheet metal specialists and are equipped to give special attention to custom work.

The food conveyor illustrated here is electrically heated with thermostatic control and has one meat pan—three two quart inserts—and four eight quart inserts.

We can make them larger or smaller.

Hospitals are on the Government's list for replacements.

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### *Formulae-Filled Booklet Free!*

Available to you is an interesting 12-page formulae-filled booklet describing this and many other kitchen sanitation and maintenance cleaning operations. Write for your copy **TODAY . . . It's FREE!**

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steam heated.

**Low Cost — Easily  
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423 Rachel Street

## Across the Desk

By C. A. E.

### What the Well Dressed Journals are Wearing

**W**E are enjoying quite a "lift" just now due to our resplendent new cover dress, which we are introducing this month. You will note that the now familiar dark green motif has been retained, as well as the distinctive lettering of the name. The tipsy angle of the graduated screen design, however, satisfies the taste of the Business Office for something a bit daring and exciting.

Definitely late, but Congratulations to "Hospitals" on their artistic new cover and new presentation of text.

\* \* \*

### Welcome!

Appearing in the Journal for the first time are advertisements by:

*Eli Lilly & Co., (Canada) Limited.* Established in 1875 in the United States, Lilly Pharmaceuticals and Biologicals have become favourably known throughout the world. They are sold only on doctors' direction. Mr. H. T. Jensen, Canadian manager, Toronto office, has had extensive experience with the organization, including many years service in the Orient.

*Singer Sewing Machine Co.,* manufacturers of the Singer Surgical Stitching Instrument. This well-known company has introduced an entirely new technique in suturing, a variety of new stitches now being at the operator's command. Films are available to hospitals who wish to have their staffs study demonstrations of this unique apparatus.

*Agfa Ansco.* Manufacturers of photographic materials since 1842, this company produces for the hospital field, high speed x-ray film for use with calcium tungstate screens and the well-known Non-Screen film for use in cardboard holders, especially intended for radiology of the extremities and soft tissues. Their Direct Duplicating film is a recording medium for making exact duplicates of x-ray films in a single step, and is also one of their well-known products for use in the medical field.

In addition to the above items, they manufacture Liquadol and Liquafix X-ray Developer and fixer in liquid form. There is also Ansco Rapid X-ray Developer and Ansco Fixer with Hardener which came in powdered form in various convenient sizes.

All of these items are maintained in stock at the Canadian branch, 60 Front Street, West, Toronto, and are available through the leading x-ray equipment and supply dealers in the Dominion.

After January 1, 1944, the company will be known as Ansco, a Division of General Aniline & Film Corporation.

*J. H. Emerson Company,* Cambridge, Mass. Feature products: The Emerson Resuscitator, an automatic, self-adjusting breathing machine for use in all cases where natural respiration has failed; Emerson Hot Pack Appar-

## TIMELY TIPS ON HANDLING FILM

# PREPARING POWDERED PROCESSING CHEMICALS

● Care and cleanliness are vital in the mixing of chemicals. Solutions must not splash, dust from chemicals must not scatter, or trouble will almost surely follow. Water supply must

be as pure as possible, otherwise sedimentary material will harm the film. Proceed only when you have these precautions firmly in mind.



**1** Before starting to mix fresh solutions, it's good practice to empty and clean tank thoroughly to remove all traces of dirt, scum and sediment. Use a bristle brush and trisodium phosphate. Then rinse thoroughly with water.



**3** Cork the bottle, turn it on its side and roll till chemicals are completely dissolved. This prevents splashing and oxidation. Then add loose chemicals in container and roll again until they, too, are thoroughly dissolved.

For dependable results with powdered processing chemicals, many roentgenologists have standardized on Ansco's Rapid X-ray Developer. A scientifically prepared and particularly blended formula, it is an excellent choice for use with all Ansco X-ray films as well as with Ansco Direct Duplicating Film and Electrocardiograph Film and Paper.

Ansco's X-ray Fixer with Hardener is also recommended for excellent results and long (cost-saving) life. **Ansco, Binghamton, New York.** A Division of General Aniline & Film Corporation.



**2** A handy way to prepare dry developing chemicals is to use a 5 gallon bottle. Make sure it's clean, then fill it half full of warm water (125°F.) and add contents of small fibre tube enclosed in large container. Use a funnel to avoid spilling or scattering chemicals.



**4** Just fill the bottle with cold water—and you've got 5 gallons of ready-to-use solution. If possible allow it to stand overnight before using. Developer can be stored indefinitely in the bottle. (Dry fixing chemicals are mixed and stored in the same manner).

### Ansco

(FORMERLY AGFA ANSCO)

## X-Ray Films and Chemicals

KEEP YOUR EYE ON ANSCO—  
FIRST WITH THE FINEST

## Hospitals of Any Size can purchase requirements of Standard Record Forms at economical quantity production prices . . . .

WRITE FOR SAMPLES AND PRICE LIST.

**Hanger Cards** { These titles in stock  
7¼ by 4½ inches "Treatment Being Given"  
punched, corded; choice "Silence Please"  
of brown, blue or green. "Patient Sleeping"  
"No Visitors Please"

Special cards, one or a dozen or more made to order by our Embosograf process; choice of several color combinations; ask for quotations.

**HOSPITAL & MEDICAL RECORDS  
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The new Castle "Duplex" tray frame and two full size instrument trays, permits your present dressing sterilizer to do double duty. First as a dressing sterilizer, then as a pressure Instrument Sterilizer.

Light in weight, this easily handled cradle can be put in place or removed in an instant.

Designed for use in ANY Autoclave of 14", 16" or 20" Diameter Dressing Sterilizer.

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atus for the preparation of hot packs for the Kenny treatment and other purposes.

Ingram & Bell Limited are the Canadian distributors.

(For complete list of advertisers see Index of Advertisers opposite inside back cover, each month. When writing to any of our advertisers, please mention The Canadian Hospital).

\* \* \*

### Storage Facilities

During the period of "stocking up" with all sorts of hospital supplies, many institutions were inconvenienced by a lack of storage space. A salesman for one of the big supply houses found that in some cases storage facilities were not given sufficient consideration in original building plans. In other instances ample store rooms had been provided, but encroachments by other expanding departments had simply converted these rooms into service departments. Has any hospital ever had too much storage space?

\* \* \*

### Make Tentative Plans Now

Post-war plans are already in the making. Victor X-Ray Corporation say that not a few foresighted hospital administrators and roentgenologists have wisely decided against putting off, for the duration, projects which might be worked up to more or less tentative plans now. Thus they aim to avoid possible confusion and delays, come the day when innumerable projects will be begging for time and attention.

\* \* \*

### A Church Going Golfer!

A friend of ours, a consistent church-going golfing enthusiast, (we'll admit it doesn't seem to make sense) carries his golfing technique to church. When the hymns are announced he carefully sizes up his hymn book and then aims to open the book near the required hymn number. He claims it is surprising how often he can arrive at the correct page in four or five tries—in other words, "par".

\* \* \*

### I Boils Me Tools

In our December issue the concluding advertisement of its "Torch Bearers of Surgery" series by Crane Limited was published. The theme is worth repeating:

An old veterinary surgeon of Yorkshire, England, acquired local fame because his "patients" so seldom died of infection. His friends observed that, before every operation on an animal, he insisted on being left absolutely alone in the farmhouse for at least half an hour. When the old man was dying, his son begged him for his secret of success. Drawing his son close to the bedside, the dying man whispered, "I boils me tools".

\* \* \*

### Post-War Thought

Think of the appalling condition of chaos which will prevail throughout Europe after the war. Destruction of administrative offices with records; bombed out power stations, bridges, railroad stations, locomotive works and repair shops, factories and retail establishments. As a result of Nazi intrigue and currency manipulations,

The CANADIAN HOSPITAL

# ANNOUNCING—

## THE UNION OF TWO GREAT THERAPEUTIC AGENTS

# Neo-Synephrine Sulfathiazolate

combines powerful vasoconstriction  
and potent bacteriostasis in one  
stable chemical compound



In response to widespread demand, Stearns research has linked into one stable chemical compound the vasoconstrictive properties of Neo-Synephrine and the bacteriostatic action of sulfathiazole.

The worth of this new product can be judged from the fact that the therapeutic value of both agents is undiminished.

Neo-Synephrine Sulfathiazolate pro-

vides the same fast, sustained decongestion of engorged mucous membrane as Neo-Synephrine, with the same relative freedom from undesirable side effects — combined with the bacteriostatic potency of sodium sulfathiazole.

Convenient to use and safe to administer, Neo-Synephrine Sulfathiazolate provides the medical profession with a powerful new tool for the alleviation of symptoms of colds and sinusitis.

NEO-SYNEPHRINE SULFATHIAZOLATE—for topical treatment of colds and sinusitis—is available in 1-oz. (with dropper) and 16-oz. bottles as a 0.6 per cent solution in a buffered, approximately isotonic vehicle.

Frederick **Stearns** & Company  
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For  
**ECONOMY and SANITATION**

"A place for everything and everything in its place" is a medical necessity—towels, sheets and all linens should be marked for each ward or department with CASH'S WOVEN NAMES. Uniforms and all wearables of nurses, orderlies, doctors should be identified individually. Lost laundry, mislaid linen, wrongly used towels mean losses in money, in time, in sanitation, in good management.





CASH'S NAMES will stop these wastes, cut replacement costs, identify instantly. They are the sanitary, permanent method of marking. Quickly attached with thread. (NO-SO not available for duration).

Write and let us figure on your needs—whether institutional or personal.

12 doz. ....	\$3.00	9 doz. ....	\$2.50
6 doz. ....	\$2.00	3 doz. ....	\$1.50

(Larger size, wider tape names, discontinued until further notice)

**CASH'S** 174 GRIER STREET  
BELLEVILLE, ONTARIO

**GUARANTEED\***  
to get rid of  
**ROACHES**  
-or your money back!

**Saphelle**  
POWDER (P.C.P. Act. 82)



**EASY TO APPLY**—Fold paper or cardboard in "V"—sprinkle line of Saphelle along wall bases, mouldings, window and door frames and in all cupboards.

**ACTIVE FOR WEEKS**—Leave powder exposed for three to four weeks, then repeat application. (Or if you wish, make more frequent applications for shorter periods.)

\*If, after two applications, satisfactory results have not been obtained, return the balance of the package to us and we will refund the full purchase price.

**A SAPHO PRODUCT**

Made by the makers of Sapho Liquid, Sapho Liquid Odourless, Sapho Powder and Saphine. Saphelle is sold in 5-lb., 10-lb., 50-lb., 100-lb. and 250-lb. quantities.

**The Kennedy Manufacturing Co.**  
112 McGill Street MONTREAL



QUEBEC OTTAWA TORONTO WINNIPEG VANCOUVER

whereby they have taken control of thousands of business and residential properties, a clear title to anything worth while will be an oddity. Setting things in order again will be one of the most tremendous jobs in history.

\* \* \*

**W. J. Edwards to Calgary**

Early in Decemebr, Mr. W. J. Edwards of Ingram & Bell, Limited, took over the management of their Calgary branch. Mr. L. J. Harvey, branch manager since the establishment of this office, has retired. Mr. Edwards has been general sales manager of the firm for a number of years, with headquarters in Toronto. He formerly was western traveller out at the company's Winnipeg office.

\* \* \*

**Blood Bank at Kingston**

The Blood Bank at the Kingston General Hospital will include a Stato-Freeze Unit. This equipment, made by Chatham Malleable and Steel Products, Ltd., accommodates 6 Baxter F-10-S bottles in the Wedge-Freeze tubes and provides frozen storage compartment for another 200 bottles. In addition, there is a medium temperature storage compartment. Several other Canadian hospitals are already buying similar equipment for Blood and Plasma Bank storage use.

\* \* \*

**In New Zealand Hospitals**

In New Zealand there is one nurse to 1.8 hospital beds. The average ratio of registered nurses to pupil nurses is one R.N. to 2.8 pupil nurses. Ward maids and cleaners are used freely.

New Zealand pupil nurses work an eight hour day, on the three shift plan. They have a weekly day off, and three weeks annual leave on full pay.

\* \* \*

**They Tell Us—**

**Pharmacy**—Owing to the shortages of many items such as candy, films, ice cream and so on, and the greatly increased volume of prescription business, drug stores are again really becoming *drug stores*.

Lack of an attractive future for pharmacists is curtailing enrolment in Colleges of Pharmacy. Indications are that in five to ten years there will be a shortage of 800 qualified pharmacists.

**Agriculture**—The debt of farmers to farm machinery manufacturers, on implement account, has practically been liquidated during the past four years.

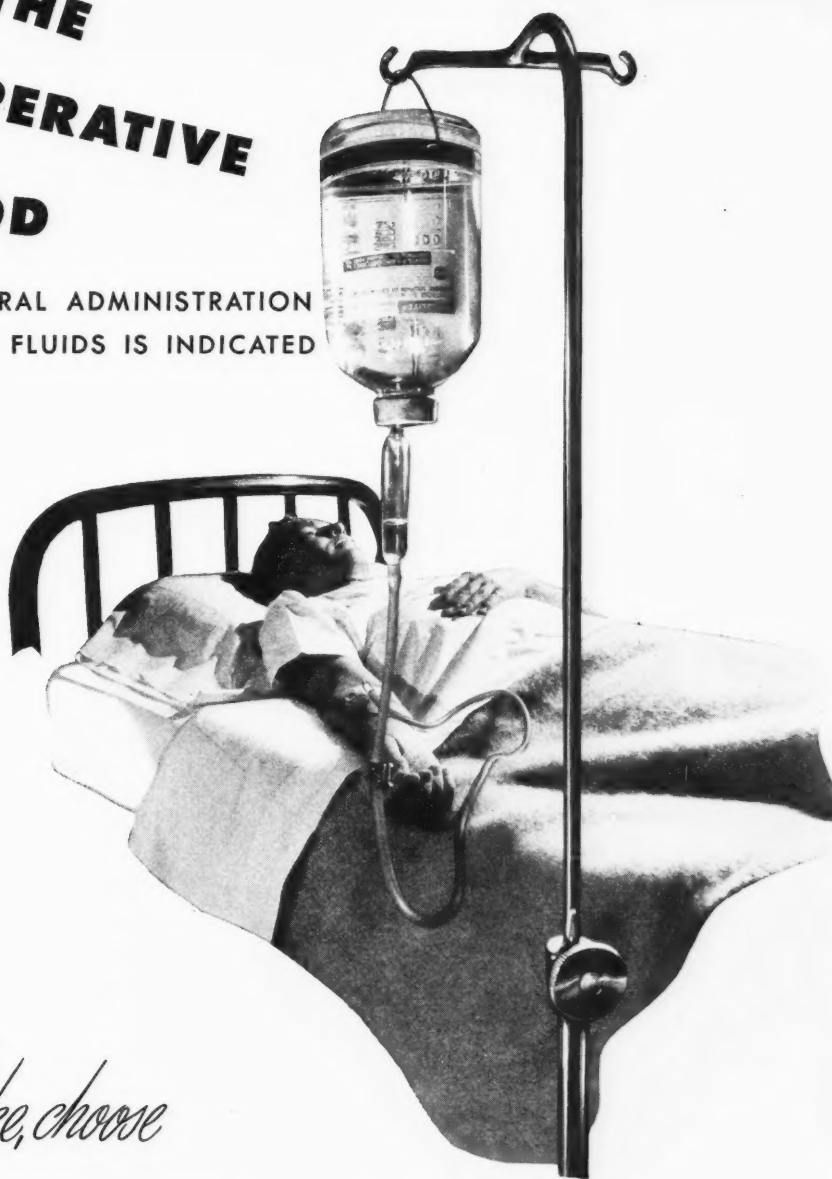
Price increases of farm products, since March, 1939, average 75 per cent. Farmers have improved their economic position better than any other group.

Poor grain crops, especially in Ontario, will be the main factor in reduced production of bacon during 1944.

The CANADIAN HOSPITAL

FOR THE  
POST-OPERATIVE  
PERIOD

WHEN THE PARENTERAL ADMINISTRATION  
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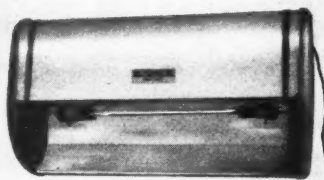
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# CANADIAN HOSPITAL

Harvey Agnew, M.D., Editor

Toronto, January, 1944

Vol. 21

No. 1

New Construction Co-ordinates  
Rural and Urban Facilities

## Mexico Takes Lead in Hospital Building Programme

THE hospital construction programme in Mexico, now well under way, might well be given serious consideration by those interested in hospitals in other countries. The President of the Mexican Republic, General Manuel Villa Camacho, during the three years of his government has taken a most active interest in the social welfare of the people and has strongly supported the health programme of his Minister of Welfare, Dr. Gustavo Baz. Speaking at the Buffalo convention of the American Hospital Association, Dr. Baz, who is a noted neuro-surgeon in his professional activity, referred to the intensive governmental programme as one of "economic recovery and social rehabilitation based on a modern system, scientifically conceived and efficiently carried out".

Speaking of the plan he stated: "The Government of my country is building important highways on a large scale, greatly increasing the number of schools, providing ample systems of irrigation and, in addition, is putting into practice all measures tending to complete the process of balancing the economic structure of

the nation. During these difficult and distressing times, the mind and spirit of all people who are conscious of their responsibility, and every government which loves and values freedom and the other individual rights of man, must be utilized exclusively and to the fullest extent as a contribution to victory and the final tri-

umph of justice over those who try to crush mankind under the yoke of degrading slavery."

With reference to the health and social welfare programme Dr. Baz noted: "We have modernized the methods of social welfare for children and the socially weak, such as the mentally defective, the blind, the deaf mutes and so forth. The Government of my country is deeply conscious of the urgent and growing necessity of providing its people with medical care. Geographical and climatic characteristics of Mexico contribute to the inherent problems of epidemic and endemic diseases such as malaria, intestinal parasitism and other grave maladies such as onchocercosis; and these constitutes, in some zones of the country, a major source of physical impairment of the inhabitants and economic instability."

A complete network of modern hospitals covering the whole country is now under construction. It was quickly found that the old institutions were quite unable to meet the needs of the people or to furnish good medical service.

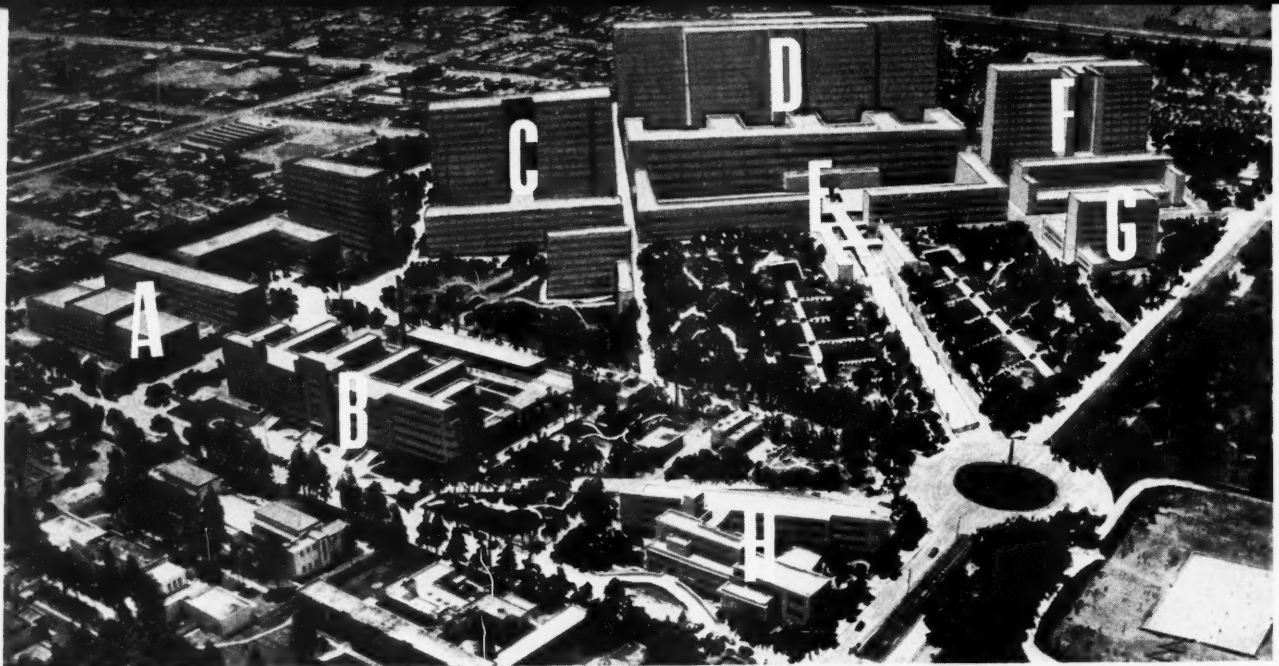
After long and careful study a



Dr. Gustavo Baz,  
Minister of Welfare, Mexico

MEDICAL FACULTY.

McGILL



*Aerial view of partially constructed Medical Centre in Mexico City showing left to right: (A) Maternity building, (B) Children's unit, (C) Infectious Diseases Hospital, (D) General Hospital, (E) Medical School, (F) City Emergency Hospital, (G) Private Clinic, (H) Cardiac Institute.*



*Above—Arturo Mundet Maternity Home.  
Below—Rear view of Cardiac Institute showing porches and ramps.  
From porch of Children's Hospital.*



series of new hospitals was designed by a group of architects and physicians who had specialized in hospital construction. The newest ideas in Europe and the Americas were studied and plans developed which embodied their most desirable features, but which could be considered as distinctly Mexican. A study of the illustrations bears testimony to the fact that the architects did not hesitate to discard conventions and to reach into the future in laying out their buildings. "Each unit has been studied as to its specific and individual purpose and in its relation to the community. The economic possibilities, the cultural and ethnical, the physical and climatic characteristics have been considered, taking full advantage of any favourable natural elements. Natural sites have been selected. Sunshine, winds and rainfall have been studied in the different parts of the country so that these may be fully utilized."

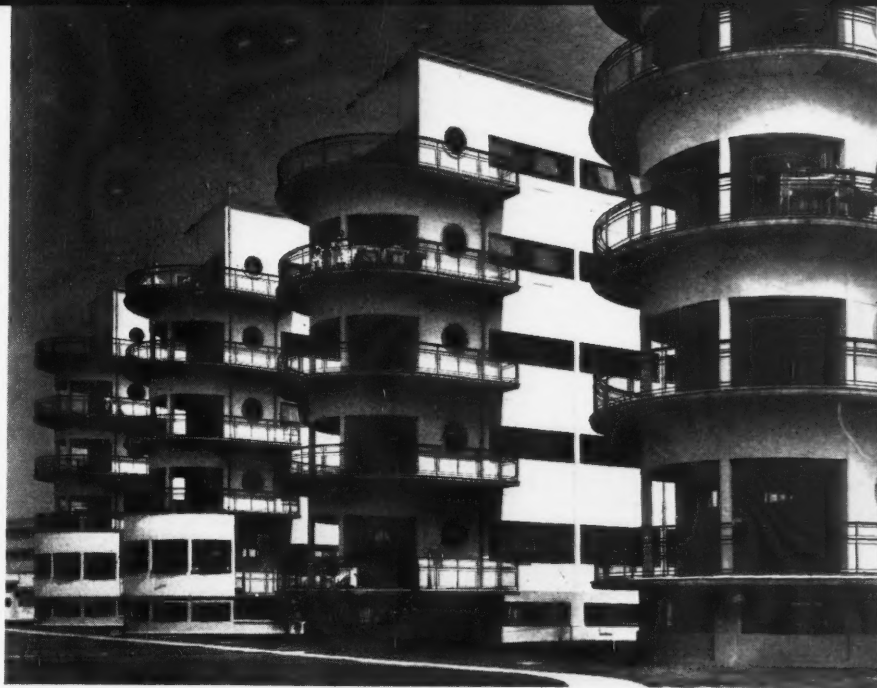
A feature of this vast hospital construction programme is the setting up in Mexico City of a large Medical Centre which will include a large general hospital of 1,200 beds, a 600-bed City Emergency Hospital, two maternity units, one of 300 beds and one of 200 beds, a 300-bed infectious diseases hospital, a 120-bed cardiac institute, a 600-bed children's hospital, a private clinic, a medical school and a dental college. In all there will be some twelve units, including a convalescent hospital in the suburbs.

The Children's Hospital is already

functioning (see *The Canadian Hospital*, December, 1941), and the Institute of Cardiology has recently been opened. The Mundet Maternity Home and the Infectious Diseases Hospital are now under construction. The plans and designs for the central General Hospital, the scientific centre of this group of buildings, have been completed and it is anticipated that construction will start shortly. Plans for the City Emergency Hospital are almost finished.

Three large hospitals in other parts of the country have already been completed—the hospital at Monterrey with 500 beds, the hospital for chronic patients in Tepexpam with 750 beds and the hospital of Manzanillo with 150 beds. Rapid progress is being made in the construction of six more hospitals in San Luis Potosi, Tuxtla Gutierrez, Salvatierra, Puebla, Saltillo and Tampico; as well as the Home for Mentally Defective Patients in Leon, the Maternity Homes of Chihuahua and Parral and the Prenatal and Postnatal Clinic in Mexico City.

The construction has already begun of eight more hospitals in Veracruz, Jalapa, Tuxpam, Cosamaloapan, Coatzacoalcas, Hermosillo, Mazatlan and Tepic, and of the Prenatal and Postnatal Clinic in Tacubaya. The authorities are at present studying



Above—Sun balconies on rear of Children's Hospital.  
Right—Infectious Diseases Hospital.  
Below—City Emergency Hospital.





*Above—300-bed hospital at Saltillo, Coah.*

*Right—130-bed hospital at Coatzacoalcas, Ver.*

*Below—Design for a building for subacute or convalescent patients. Note ample open-air space, either in or protected from the sun; also covered ramps between buildings.*



the plans and designs for eleven hospitals in Acapulco, Tlaxcala, Tulancingo, Ometepe, Merida, Campeche, Guadalajara, Yahualica, Papantla, Monclova and Colima.

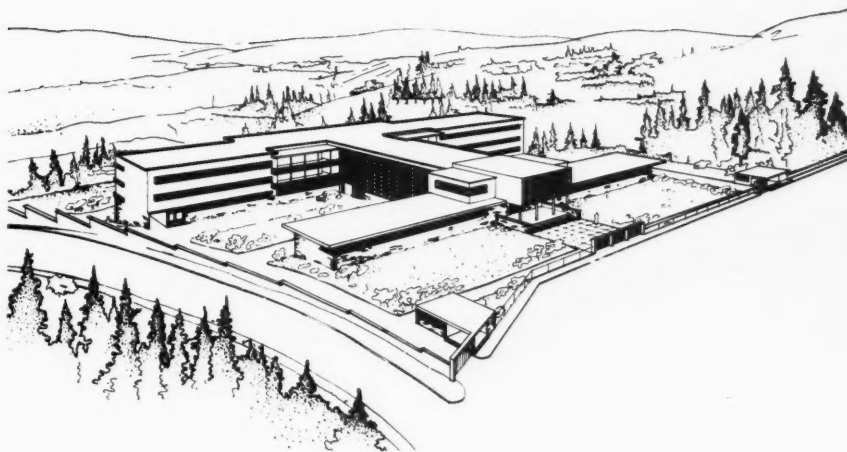
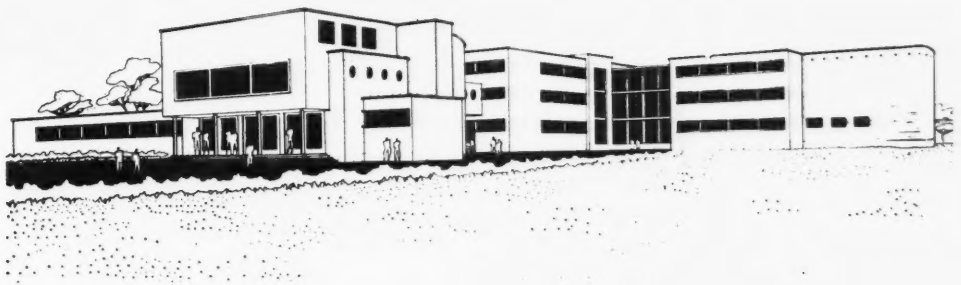
Among the architects who have participated in the designing of these plans are: Enrique del Moral, Enrique Carral, Mario Pani, Alonso Mariscal, Carlos Tarditi, Jose Villagran Garcia and Mauricio M. Campos.

Consultants: Doctors Samuel Morones, Norberto Trevino, Esteban Dominguez, M. Salazar, Gustavo Viniegra, Antonio Sordo Noriega, and Pedro D. Martinez.

In paying tribute to the achieve-

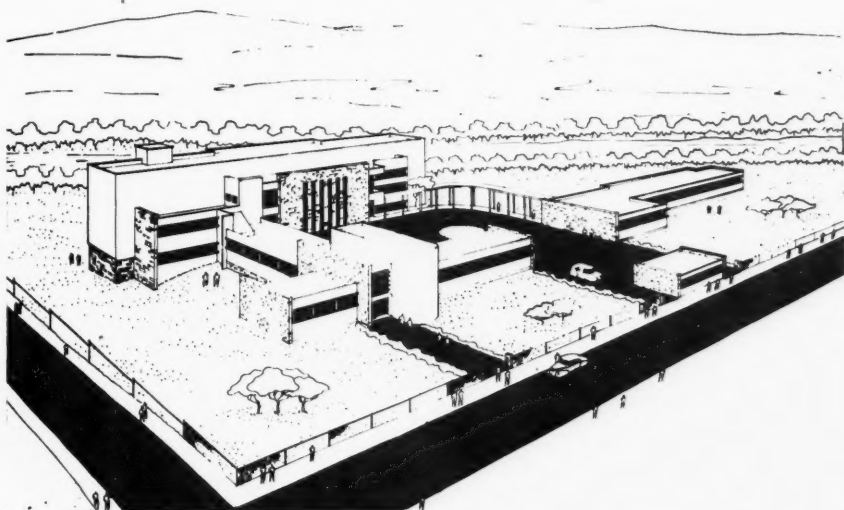
ment of those who have been responsible for this remarkable programme of hospital expansion, Dr. Baz stated: "It is most gratifying to us that the foundations of the Mexican School of Hospital Architecture have been laid as the result of the enthusiasm and vigorous action of this valuable group of experts who have created the new Mexican technique of hospital construction and operation."

We are indebted to Mr. Felix Lamela, Secretary of the Inter-American Hospital Association for the opportunity to use the illustrations in this issue.



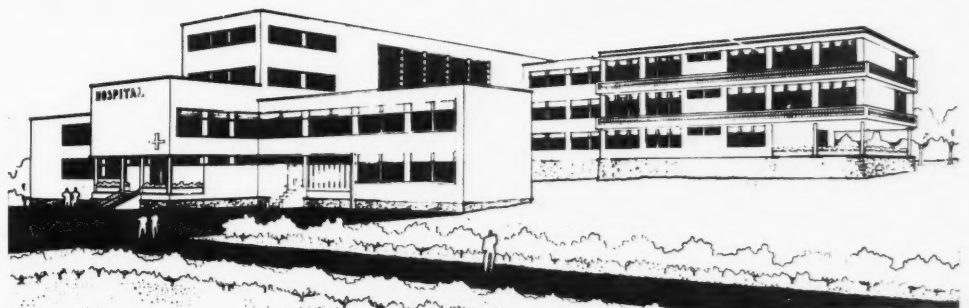
*Above — 116-bed hospital under construction at Monclova, Coh.*

*Left — 160-bed hospital under construction at Teziutlan, Pue.*



*Left — 64-bed suburban hospital proposed at Tulancingo, Hgo.*

*Below — 245-bed hospital under construction at Mazatlan, Sin.*



# Employment Conditions for Nurses

## Referred to Provincial Associations

### C.H.C. Report on C.N.A. Recommendations

THE Executive Committee of the Canadian Hospital Council has referred to the member associations for provincial study the recommendations of the special committee of the Canadian Nurses Association on salaries and working conditions for nurses in hospitals, and the report of the Canadian Hospital Council committee named to study these recommendations.

Prior to the Council meeting in September the Executive met a C.N.A. committee under the chairmanship of Miss F. Munroe of Montreal, which had prepared a number of recommendations designed to correct, in large measure, the present difficulties associated with the employment of nurses in hospitals. No action was taken at that meeting, pending the report of a special committee under

the chairmanship of Dr. J. C. Mackenzie of Montreal, named by the Canadian Hospital Council to study these recommendations. For purposes of brevity the various clauses of the recommendations of Miss Munroe's committee are given with, in each case, the observation on that recommendation by Dr. Mackenzie's committee.

The C.H.C. Executive Committee has reviewed the report of its special committee and has approved this report. The Executive is very sympathetic to the desire of the nursing profession to assure fair salaries and good working conditions for nurses employed in hospitals. It is realized that satisfactory conditions for its nursing staff are essential to the efficient operation of a hospital. While

it does not seem feasible to suggest minimum salaries applicable to the whole of Canada, a great deal might be done in local areas or in provinces.

With this in mind, and also because it has been the policy of the Canadian Hospital Council to refer to the member associations any matters which would involve substantial financial outlay by the hospitals, these recommendations from the two committees have been sent to all provincial associations and the conferences, with the recommendation that joint committees representing both the nurses and the hospitals be set up in each province. It is suggested that these joint committees could then consider the recommendations in the light of conditions prevailing in the respective provinces.

\* \* \* \* \*

### C.N.A. Committee Recommendations

The Canadian Nurses Association is very aware of the difficulties with which hospitals are contending at the present time in supplying essential nursing service under existing conditions and appreciate the serious implications in relation to the health and welfare of the public.

It is further realized that while blame for the present difficulties is placed upon nurses, in justice to them they should not be expected to bear the full responsibility. Furthermore, it is felt that nurses should be given the same consideration that is afforded to other workers under present conditions.

The recent Survey of Nursing shows that salaries for nurses are low, hours of duty are long and that there is a definite shortage of nurses to meet the demands.

In order to support:

(1) the stabilization of existing general duty staffs, it is recommended that:

- (a) the minimum salary for the general staff nurse be \$100 a month plus meals taken during hours of duty plus laundry. Furthermore that two weeks' vacation with salary be granted at the end of each

### C.H.C. Committee Observations (abridged)

Your Committee begs to report that it has examined in detail and closely considered the recommendations of the Canadian Nurses Association in respect to the remuneration and hours of work, etc., for the general staff nurse.

Your Committee would point out that inasmuch as each province is autonomous in matters pertaining to health, it is of the opinion that it cannot frame a series of recommendations as such must be contrary to ordinances already enacted under provincial law, or that may be enacted in the future; hence the Committee's observations are to be taken only as a guide.

Your Committee would further draw to your attention that it is of the opinion that the setting up of minimums should be a matter of arrangement between the Provincial Association of Registered Nurses and the Provincial Hospital Association or their counter-parts, and that once such has been agreed upon overtures should be made to the Provincial Government by the two bodies jointly and/or any other bodies concerned, for the enactment of such minimums.

#### Observations:

It is the opinion of your Committee, for the reasons given in the preamble, that a set minimum salary of \$100 per month applicable to Canada as a whole cannot be

#### C.N.A. Committee Recommendations

year of service for those remaining a second year, also a minimum of two weeks' sick leave with salary each year if necessary, the latter not to be accumulative;

- (b) for a period of general duty of under one month and of one week or over, a salary of \$4 a day be paid;
- (c) for less than one week, salary be paid for general staff duty at prevailing private duty rates, plus one meal while on duty; in each instance it is understood that the nurse will provide her own room; (Divided opinion)
- (d) hours of duty for the general duty nurse be eight working hours per day, consecutive if possible, exclusive of meals, for a six-day week;

(2) the utilization of present and available nursing resources for nursing duties, it is recommended that:

- (a) every effort be made to avoid wastage of nursing time and effort by elimination of non-nursing duties for the nurse, simplification of nursing procedures and other recognized measures;

#### C.H.C. Committee Observations

recognized in view of the fact that wages and working conditions for the same type of work differ from province to province, or from zone to zone in each province. Your Committee, therefore, suggests that in order to arrive at an equitable remuneration for general staff nurse services from one locale to another, that the average current earnings of equivalent nursing services for that locale be used as a guide, e.g., average remuneration of the special duty nurse or other nurses similarly earning their livelihood as nurses but engaged outside of hospital payrolls. That having arrived at such an equivalent salary, the emoluments which the general duty nurse enjoys should be valued in terms of their cash benefits, and so deducted from the equivalent salary in order to arrive at the net salary payable by the hospital in cash.

##### *Observation:*

In agreement as long as it is understood that there will be no other emoluments than the monetary one mentioned.

##### *Observation:*

In agreement.

##### *Observation:*

In agreement as a condition of employment to be aimed at. Even though it may conflict with certain provincial ordinances, it still can be made effective by the dictates of supply and demand.

##### *Observation:*

Agreed.

*(Concluded on page 26)*

## How Australia Meets the Shortage of Doctors

The shortage of doctors for civilian needs is felt in other countries besides Canada. Down in Australia they have worked out a plan which seems to be well suited to their particular needs.

They have adopted what are called National Security (Medical Co-ordination and Equipment) Regulations. By these regulations all medical practitioners under 60 years of age except those who are in the armed forces may be called upon to serve as medical officers in what is called the "Citizens' Forces". Doctors coming under these provisions must attend for medical examination and then are required to serve within the Commonwealth wherever appointed.

The Central Committee may call upon the doctor to serve in what is called the Emergency Civil Medical Practitioner Service. The period of service may be specified. Also, the doctor may be directed to serve as a visiting or resident medical officer in any public hospital or institution.

Pay and allowances for the medical practitioner will be at the rate payable to medical officers in the A.A.M.C. If desired practitioners may serve in an honorary capacity or in other instances may receive from a hospital or institution the usual salary paid for the type of work undertaken.

Medical officers may practice in an emergency.

There is a Central Medical Co-ordination Committee. The Committee is made up of the three directors of the armed medical service; two members representing the British Medical Association in Australia, a representative of a joint council of the Colleges of Physicians and Surgeons, a representative of the Manpower Directorate of the Emergency Medical services, Director General of Health, a representative of Adjutant-General, the Secretary of the Department of Home Security and one member appointed by the Minister. The D.G.M.S. is chairman of this Committee.

There are state committees also, the Deputy Director of Medical Services being Chairman and with the membership made up upon a somewhat similar basis to that of the Central Committee.

**C.N.A. Recommendations**  
(Continued)

- (b) the services of the private duty nurse be limited to those whose condition justifies individual nursing care. It would seem that the appropriate control of the use of the private duty nurse should be a matter of arrangement between the attending physician, hospital authorities and professional registry, and that available nursing resources should be taken into consideration in each instance;
- (c) consideration be given to ways and means of minimizing wastage of nursing service caused by shortage of maids, orderlies and aides;
- (d) the immediate and increased use of subsidiary nursing groups be instituted to meet present shortages; this to include:
  - (i) the execution of plans by provincial nurses' associations for the training of these groups as already approved by the Canadian Nurses Association;
  - (ii) the use of volunteer workers when available.

It is recommended that representatives of the nurses' association and hospital association in each province co-operate in formulating plans for the preparation, definition of duties and appropriate control of the subsidiary nursing worker, and that these workers be known as "nurses' aides".

This committee is opposed to the freezing of nurses in positions. However, the Canadian Nurses Association has already endorsed a policy whereby nurses would be required to remain in nursing.

**C.H.C. Observations**  
(Continued)

*Observation:*

Agreed.

*Observation:*

Agreed.

*Observation:*

(i) and (ii) Agreed.

\* \* \*

*Committees*

*C.N.A.*

Miss F. Munroe,  
(Chairman)  
Miss M. Lindeburgh  
Miss M. Baker  
Miss G. Hall  
Miss K. W. Ellis  
Miss E. Flanagan  
Miss E. Beith  
Mother Allaire  
Sister Allard

*C.H.C.*

J. C. Mackenzie, M.D.,  
(Chairman)  
George F. Stephens, M.D.  
R. Laporte.  
A. F. Anderson, M.D.

**Self-Education**

Self-education need not be a laborious process of reading rigid rules, applying, and gauging one's progress. The admitting officer, whose surly manner on occasions bespeaks ulcers or home troubles—to the hospital's loss—may be informed of the responsibilities of his office by a newspaper article. If one of a series of exploratory articles on the functions and paraphernalia of a hospital were devoted to the admitting officer, and elaborated on the nice manner with which he meets the public, and if it carried such a tone throughout the entire article, closing with his gracious handling of the paying guest who is being discharged, it is almost a foregone conclusion that your admitting officer will live up to his public portrait.

The same treatment will be effective for all groups of personnel within the hospital, as well as for

members of the board, donors and volunteers. Self-education is the slow or sudden awakening to the public education programme of the hospital and to the special aspect of it with which we are concerned. The potential donor reads of the good work of the hospital, recalls that the hospital once saved the life of his Uncle Jethro, notes the deficit in the annual report, considers the high income tax he faces this year, computes the saving to be made through a gift to the hospital, seizes his pen and writes the cheque. Perhaps his self-education is assisted by personal contact with members of the board, or by actual hospitalization—which opens his eyes. The projected programme is aimed to cut short the time required for self-education.

—From "Public Education Programme" by the Council on Public Education, A.H.A.,

# Influenza

By J. J. HEAGERTY, M.D.,

Director of Public Health Services, Department of  
Pensions and National Health.

**I**NFLUENZA has been epidemic throughout the world on innumerable occasions. A summary of the various world epidemics will be found in such works as Hirsch's *Handbook of Geographical and Historical Pathology*, Creighton's *History of Epidemics in Britain*, Theophilus Thompson's *Annals of Influenza* and Leichtenstern's *Influenza*, and in other treatises. There is a difference of opinion in regard to these epidemics. For example, an epidemic which occurred in France during 1769 is accepted by Kusnezow and Herrmann (1890) as influenza, but rejected by Ripperger (1892). Again, the epidemic of 1737, although generally accepted as influenza, is characterized by Gluge (1837) as a "nervous fever". Jordan in his book entitled, *Epidemic Influenza*, points out that there is general agreement as to the essential identity of the majority of historical pandemics. Opinions regarding the nature of these outbreaks are based upon clinical and epidemiological appearance as no organism was definitely identified as being associated with any of these outbreaks. Practically all observers attest to the similarity of the 1918-1919 outbreak to that of 1889, 1890 and other classic outbreaks.

## Canadian Outbreaks

In Canada there have been many epidemics of influenza. Our records of this disease in Canada go back

as far as the year 1700. There was an epidemic in the years 1818-1819-1820 both in Canada and the United States. The disease was again epidemic both in Canada and the United States in the year 1826.

The disease again occurred in epidemic form in 1835, 1836 and 1837. On this occasion it extended throughout the United States and Canada and reached the Canadian Northwest. Richard King, in his narrative of his journey to the shores of the Arctic Ocean in 1833, 1834 and 1835, says that he was detained at Rapid River Fort for three days for the purpose of administering relief to a band of Indians who were suffering from influenza.

Influenza was epidemic in 1832 but was over-shadowed by the cholera epidemic of that year, just as the epidemic of 1847-1848 was swallowed up in the typhus epidemic which was brought to the country by immigrants.

The disease was again epidemic in 1889-1890. That epidemic apparently had its beginning in Hong Kong in 1888. It spread to Russia and had reached St. Petersburg by the middle of May, 1889. By the end of November it had spread through the whole of Germany, France, Austria, Sweden, Denmark, Switzerland, Italy, Spain and through the Balkans and was carried to North America. Reaching the eastern part of Canada it spread through the whole country and reached its peak during the early part of 1890, gradually declining and reappearing in milder form for two or more years.

## 1918

In the year 1918 influenza was epidemic in Canada. At that time the epidemic was said to have had its beginning in Spain, hence the disease was known as "Spanish Influenza". From Spain it spread rapidly to all combatants in the military zone. Apparently the German troops were the first to be affected. Soon it spread to civilians throughout the whole of Europe, the British Isles and the East. It was carried by troop ships to Canada. On the 9th of July in that year, there arrived at the port of Montreal, from India, a ship, the "Somali", of which the great majority of the crew were suffering from influenza. This ship had been given clearance at the Grosse Isle quarantine station in the St. Lawrence but, on account of the fact that influenza was prevalent among the crew, was returned to the quarantine station as an infected vessel. At that time influenza was treated as a major quarantinable disease and instructions were issued to detain at the quarantine station all persons suffering from influenza for treatment and contacts for observation. All vessels on which there were cases of influenza were disinfected. The crew of the "Somali" numbered 177. Practically all of them were admitted to hospital at Grosse Isle. Of the total number, there were only two deaths, a mortality of approximately 1 per cent. It should be noted, however, that this ship arrived at the quarantine station in the summertime. The type of case at this time was mild in comparison with those that occurred later in the

Address at the Conference on Epidemics in Ottawa, December 3 and 4, called by the Committee on Epidemics of the Canadian Medical Association and sponsored by the Department of Pensions and National Health.

season and the number of cases of pneumonia among the sick was negligible.

Following the arrival of the "Somali" at the quarantine station, there was scarcely a ship that came to the eastern maritime ports of Canada that did not bring influenza into the country. As the season advanced, the death rate increased until a rate of 20 per cent was reached in October and November. An important factor in the death rate was the fact that a large percentage of the members of the crews who were ill were from the East Indies. They were not accustomed to the hardships of the North Atlantic. In many instances ships followed routes far north of their normal course where the exposure to cold increased the hazards of influenza. There would appear to be no doubt that pneumonia followed faster upon the heels of the initial influenza in the case of East Indians than is usual with Europeans.

As early as the month of August there were many cases of influenza in the City of Quebec and, on account of the rapidity with which the disease spread and the high death rate, a suspicion was aroused that plague was spreading through the country. In Quebec and elsewhere the usual types of influenza cases were noted—mild cases with chills, fever, headache, backache, coryza and conjunctivitis, sore throat and prostration; severe cases with pulmonary complications and others with secondary gastro-intestinal involvement such as nausea, vomiting and diarrhoea.

#### **Spread to Montreal**

The disease spread rapidly along the lines of travel to Montreal where it was prevalent during the latter part of September. By the month of November more than 17,000 cases were reported and 3,028 deaths had occurred in that city. The number of cases reported bore no relation to the number of persons actually suffering from the disease. There is no doubt that at this time more than 100,000 people, probably 500,000, were suffering from influenza in that city. Only the more serious cases were reported. The situation was so serious in Montreal that vigilant com-



**Dr. J. J. Heagerty**

mittees were pressed into service to go from house to house to ascertain if any of the members of the family were sick or if any assistance was required. Families were found in which all of the members were ill, unable to help themselves and unable to obtain any nursing or other services. The dead were found in bed alongside the well; in one case a mother lay ill with her two-year old child dead beside her. The number of deaths was so great that inhabitants of houses along the routes to the cemeteries kept their blinds drawn to hide from their sight the almost continuous procession of hearses and other vehicles conveying the dead to their last resting place. At the cemeteries the vaults became quickly filled and coffins were piled in rows along the roadside. The bodies were conveyed to the cemeteries in whatever vehicle was available; grocery and butcher waggons were pressed into service and hearses carried as many coffins as they could.

During the period when the epidemic was at its peak, masks were worn by physicians, nurses, workers in workshops, in the home and on the streets. These masks were made of gauze fastened over the nose and mouth. Some of them contained a wad of medicated cotton. In spite of the masks, morbidity and mortality went unchecked. The incidence of influenza was not greater where masks were not used than where they were used. Moreover, people gener-

ally complained of the inconvenience of the mask.

In the city of Montreal the peak appears to have been reached in the middle of October and from the 14th of that month to the 25th over 150 deaths were reported each day. On the 21st of October the number of deaths in that city was 201.

From the outset of the outbreak in Montreal every step that was considered practicable to combat the disease was adopted by the City Board of Health. On October 8th when the number of cases appeared to be increasing alarmingly, an emergency meeting of the Board of Health was called at the City Hall and resolutions adopted to close public meeting places, such as schools, theatres and dance halls. The clergy were asked to reduce their church functions to a minimum. Stores were ordered to be closed at 4 p.m. On October 10th a board of physicians was named to take charge of the situation and emergency hospitals were opened. The hospitals of the city pooled their resources. All of them were crowded to capacity during the period of epidemicity. Staffs for emergency hospitals were provided largely by voluntary organizations. A Hospital Committee was appointed to control admission to hospitals and allot beds. An Ambulance Service Committee helped to systematize this phase of the work. Military medical men gave great assistance in the emergency hospitals. Police, firemen and voluntary workers aided in meeting the situation by bringing food and fuel to the homes of those who could not help themselves.

The total number of cases reported in the Province of Quebec was 530,704 and the total number of deaths 13,880.

#### **Ontario**

In the Province of Ontario, the Provincial Board of Health in anticipation of an invasion of the disease distributed to every physician in the province a circular giving the latest information regarding the disease. This was followed by a circular to medical officers of health. Newspapers were used for the dissemination of the information to the laity. The Ontario Emergency Volunteer

*(Concluded on page 56)*

# A Typical Day— in the Life of a Supervisor

By MISS ETHEL NEWMAN, Reg. N.,  
Royal Jubilee Hospital, Victoria



COMING on duty at 6.50 a.m. and finding everything quiet, I have time to glance at the headlines of the paper, and keep up with the times.

The nurses arriving at 7.00 a.m., the night report is read and discussed. Follows then a ten-minute conference upon the condition of a patient, or upon some medication. I preside but try to keep the discussion among the student nurses as much as possible.

I then dismiss the nurses to start their morning duties, explaining to a junior nurse how to get a patient ready for the O.R., and reminding her to be sure and have the patient ready on time. At this point a nurse reports she has a lecture from 3 to 4 which she has forgotten to list. This thoughtlessness on her part entails a great deal of alteration on the hour sheet but I eventually get this changed (hoping it doesn't upset the student nurse's plans too badly); the patient's condition slip is made out, also, the "seriously ill" sheet, and I hurry over to the dining-room for breakfast.

On my return to the ward, I quickly check the blue-boards and drug basket, sign the drug slip, and go to the kitchen to serve the breakfast trays. This takes considerable time, as almost everyone has his or her special eggs: some must be poached, some boiled three or three and one-half minutes, and so on. This morning I had better make a little cream of wheat, too, for yesterday's tonsillectomy. This is all tiresome, but has to be done, if the patients are to be kept happy. Then the kitchen supplies must be checked and ordered for the day.

By this time it is about 9.00 a.m. and I can now start to visit the patients. This is usually a pleasant duty. As I make my rounds, I glance at the breakfast trays being removed, to see how much the patient is eating, and that there is not too much waste;



I watch the nurses at their work, making beds, bathing patients, etc., and make notes to be taken up later.

Here is a patient who had a major operation yesterday, feeling nauseated and miserable. I give one or two suggestions for the nurse to make her more comfortable and make a mental note re an intravenous, and pass on to the next bed. This patient complains of not being able to sleep, so I assure her I will do something about it for to-night and make another note to ask the doctor for some sedative. In another room a patient is getting ready to go to the O. R. I make sure that everything is being done on time; the next patient is eager to get out of bed, and try her feet. In this case I advise caution and remind her to wait

until the nurse is ready to help her; and so I pass on, sometimes admiring and chatting about the flowers, which are very beautiful, but always keeping an eye on the nurse at work. But here is a room where all is not well, and the patient is demanding to see the matron. This won't do, so I tell him, "Certainly, I will call the matron, but isn't there something I can do in the meantime?" During the ensuing conversation I make many mental notes re nursing, diet, etc.

Now comes the busy part of the day—doctors' visits, dressings, patients going to and coming from the O.R., intravenous injections to be ordered and checked, patients called to x-ray, with many journeys to the telephone; in between these duties I find time to stand by and watch a nurse doing a treatment with which she is not very familiar, and to make a quick visit to the discontented patient, by now somewhat mollified.

Can it be possible I hear the dinner wagon? It is half past eleven, so I hurry into the kitchen to check the special trays and serve lunches. This really does not take very long when everything is ready to serve, and now I send most of my nurses to lunch, and some for their hours off.





Why do patients ring their bells so much at lunch time? There is no nurse in sight, so I answer the bell, find the patient has finished her lunch and would like to rest. So I remove the tray, fix her pillows, and close the door quietly. The telephone is ringing again. Doctor Black would like to examine his patient in the Treatment Room. "Sorry, Dr. Black, your patient is having her lunch". "Will

she be finished in fifteen minutes?" Possibly, and I agree to have her ready by then. So in fifteen minutes the patient is put in the Treatment Room, all ready, but where is the doctor? Time passes on but where, oh where, is the doctor? The patient is getting more nervous every minute. At one o'clock the doctor arrives, and we very soon get the examination over, the patient deciding the waiting being the hardest part. So now to lunch. Then more visits to the sick patients to see if there is anything further I can do for them. Finally, my relief nurse arrives, and I can go off duty for my hours.

I regret to say that by this time I feel too tired to go out, so I spend my time with my feet up and a good book. A cup of tea in the kitchen with the night supervisor is very pleasant too. At 4.00 p.m. I return refreshed to the ward, check any high

temperatures, make out the hour slips for tomorrow, and at 4.30 serve the supper trays. It is quite a pleasure to serve these trays, they look so attractive with the side salads, and clean silver. I then finish writing out my nurse's order book, which I have been doing in snatches all day, and can now go to supper. During this meal I feel I have time to relax, and talk with other supervisors present.

Returning to the ward, I arrange for two new patients coming in, get the doctor's orders, and arrange to have them carried out.

Finally, I make my evening rounds, and check the charts as the nurses finish them. Here come the night nurses! I read the orders to them and then, on my way off duty, I report the day orders to the night supervisor. So ends the day of a supervisor; it might be any day for almost any supervisor.

## "The Fifth Freedom"

It has been said that the democracies are battling for the four freedoms: freedom from want, freedom from fear, freedom of speech and freedom of thought. Upon these freedoms will be established the world of tomorrow, the good life that must and will follow the successful conclusion of the war. It will be a world much closer than we had ever imagined was possible to "the parliament of man, the federation of the world". It is a world well worth struggling for, one that we have high hopes of seeing ourselves and one that we certainly must strive to win if only for our children.

But to attain that lofty goal we must gain a fifth freedom that is not mentioned by name above. It is freedom from disease. For, if mankind cannot free his body from the torment and the crippling of illness, what do the other four freedoms profit him? How can he enjoy them if his body is racked by the ravages of disease? It seems obvious that he must add this fifth freedom to the other four as his objectives for a better world.

In the struggle for the fifth free-

dom, one of the greatest obstacles to victory is the rising threat of tuberculosis. We are in the midst of a great world-wide war, in which tanks and armoured cars clash, airplanes sweep the skies, and vast fleets of warships patrol the seas. All through the smoke and din of battle there rides a silent, sinister figure which takes toll of warriors and civilians alike. As the battle waxes hotter and more furious, as the foundries and the forges spew out countless war machines, tuberculosis strikes down its victims, heedless of which side they are on. To us, tuberculosis is an enemy as deadly as the Nazis and their satellites, a foe that must be faced and beaten, or we die.

Tuberculosis delights in a war. Men and women have let down their guard, so to speak, against the inroads of disease. The demands of war are great. War takes prodigious sums of money, it eats up material resources, it takes the lives and the time of innumerable men and women. It consumes all the things that in peacetime are devoted in part to the creation of good health and the elimination of disease. When this guard

is let down, tuberculosis strikes. It has struck in Canada, and struck hard, though many may not know it.

Last year, the death rate from tuberculosis in Canada rose from 50.6 per 100,000 of population to 53.1. The total number of deaths increased from 5,789 in 1940 to 6,057. The effects of the war upon the population were clearly shown in these figures. As our war industrial effort approached a peak and our manpower was strained to meet the exactions of the war effort, tuberculosis crashed a blow into our conceit. Perhaps we thought we were immune. Our anti-tuberculosis work has been pretty good, we said to ourselves: "It can't happen here". But it did.

The important point is that Canadians can't afford to let tuberculosis make these gains. We have been twenty years getting tuberculosis deaths down to a rate of 50 per 100,000. And we lost it in one year. Unless we do something about it quickly and energetically, tuberculosis this year and next will gain again. It can happen here, and we can stop it.

—*Bulletin, Canadian Tuberculosis Association.*

# Mental Patients with Tuberculosis

## Present Special Problems

By O. V. DENT, M.D.,

Superintendent, Ontario Hospital, Woodstock, Ont.

THE Tuberculosis Unit of the Ontario Hospital at Woodstock is a hospital of more than 600 beds to which mentally ill patients with active tuberculosis are transferred for treatment from any of the thirteen Ontario Hospitals (for mental patients), as soon as it is discovered that their lesions are active. Also, patients in sanatoria who develop mental illness and are certified as mentally ill are admitted direct to this unit from the sanatoria.

As far as possible the tuberculosis unit is conducted on principles similar to sanatoria. However, it is not always possible for a mentally ill patient to co-operate, or to be trained to use a sputum cup, to cover his mouth while coughing and to avoid coughing in the face of staff members or of fellow patients. A number have no compunction in their sputum disposal and expectorate at random on the floor, bed linen, furniture, or whatever happens to be within range. Grouped according to the nature of their mental illness, patients with known positive sputa are placed in the same dormitory and the staff are aware of this arrangement.

Since the patients are not all able to co-operate in the prevention of the spread of infection to staff, the onus of protection rests with the staff members themselves; therefore, we have given the staff explicit directions in order that they may be better fitted to protect themselves. Each new staff member, male or female, is given on entering the service a ten-page mimeographed pamphlet, "Brief Notes on Tuberculosis for Nurses" and also a two-page pamphlet in duplicate, "Instructions to Staff Attending Tuberculosis Patients". In the latter case, he signs and returns one copy of file, signifying that he has read these instructions. Later the ward supervisor, physician or others

stress and explain these instructions after the new staff member is on duty, especially if it appears that he does not understand thoroughly or is not putting into practice the instructions as outlined.

### Routine Procedures

Fine gauze or buttercloth masks are worn over the nose and mouth, smocks or gowns are worn by female staff and white suits by male staff while on the wards. Dressing and wash rooms are provided in each building for nurses, domestics, male attendants and physicians respectively. Here the staff member removes his street clothes, places them in a clean locker, and puts on a clean mask. He then goes to the potentially contaminated sections of the dressing room to don his or her ward uniform, before reporting for duty on the ward. When going off duty the procedure is the reverse—the ward clothing is removed and placed in the individual locker in the "contaminated" sections of the dressing room, the mask is removed and placed in a receptacle for soiled masks, and the staff member "washes up" and dons the street clothing.

The staff member is advised to instruct the patients as far as possible in the use of sputum cups, the care of infected material, covering the mouth when coughing, etc.

Grossly contaminated linen is placed in an antiseptic solution, such as one of the phenol compounds, before going to the laundry. The laundering is done by steam sterilizing washers.

Dishes from the wards are washed in a steam sterilizing dishwasher, except in certain parts of the hospital where it is not convenient to bring them to the central dishwasher; in these locations they are washed in one of the recognized dish-washing solutions having chlorine as the active ingredient.

The floors are swept one to three times daily with the use of one of the recognized oily sawdust compounds to prevent the raising of dust. They are scrubbed with mops daily, using an antiseptic solution in addition to soap. The staff members are warned to agitate bed clothing and linen as little as possible.

In collecting sputum cups the staff member wears utility gloves, fills the cups with sawdust, wraps them in newspaper and places them in oiled paper bags to be sent to the incinerator for burning. If sputum is spilled, sawdust is thrown on it and it is swept up and disposed of as in the case of sputum cups; then a full-strength antiseptic of the phenol group is poured over the area and left for five minutes. Following this the area is mopped with boiling water. Sputum cup holders are sterilized daily by boiling.

Other material, known to be or potentially grossly contaminated, is handled with gloves.

### Guarding Health of Staff

In addition to the procedures just mentioned, the staff members are warned to report immediately any abrasion or laceration, no matter how insignificant it may seem, in order

*(Continued on page 44)*

**It is not always possible for a mentally ill patient to co-operate, or to be trained to use a sputum cup, to cover his mouth while coughing and to avoid coughing in the faces of staff members or of fellow patients. A number have no compunction in their sputum disposal and expectorate at random on the floor, bed linen, furniture, or whatever happens to be within range.**

An address to the Ontario Hospital Association, Toronto, October, 1943.



Was  
St. James'  
at York

## our First Convalescent Hospital?

**I**N this year of our Lord 1944 when we hear by radio that thousands of casualties have been evacuated by aerial ambulance from Sicily and Italy to North Africa within a few hours of being wounded, it is difficult to realize that during the engagements of our troops at Niagara in 1814 they did not reach their destination, York, now Toronto, less than forty miles across the Lake, until the evening of the second or third day; Nor is it generally known that the humble precursor of the present stately St. James' Cathedral in that city was pressed into service as an emergency hospital—and proved better adapted for that purpose than the regular hospital.

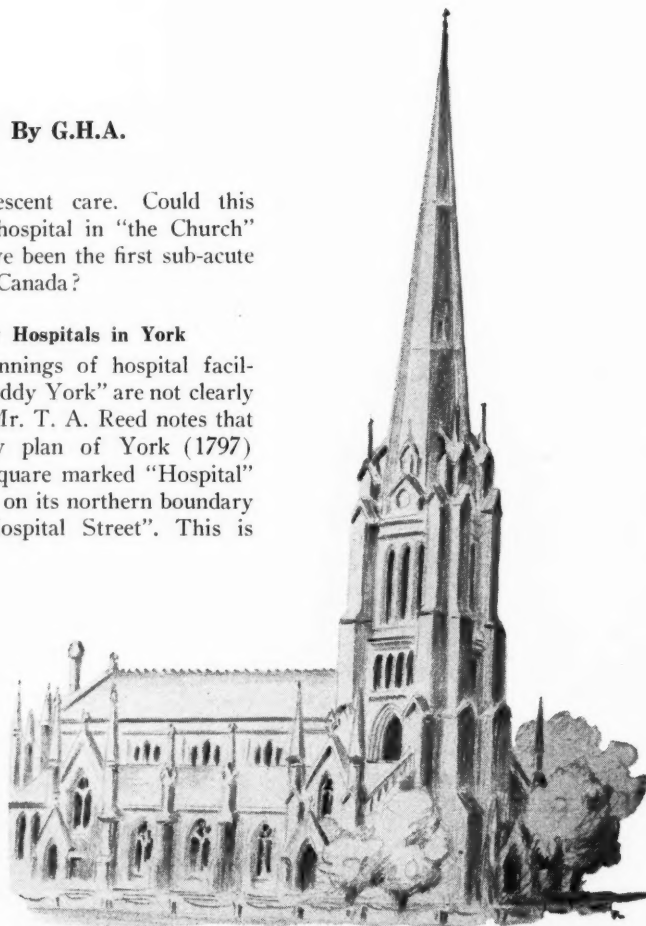
We hear much to-day of the need for sub-acute hospitals, such as the Astley Ainslie Institute in Edinburgh, to relieve hospitals for acute diseases of patients not quite ready

By G.H.A.

for convalescent care. Could this temporary hospital in "the Church" at York have been the first sub-acute hospital in Canada?

### Early Hospitals in York

The beginnings of hospital facilities in "Muddy York" are not clearly recorded. Mr. T. A. Reed notes that in an early plan of York (1797) there is a square marked "Hospital" and a street on its northern boundary marked "Hospital Street". This is



*Above—St. James' Church, York (Toronto). First building commenced 1803. Drawing by the Hon. George W. Allen of Moss Park (1845) for "Annals of the Diocese of Toronto".*

*Right—St. James' Cathedral to-day.*

now known as Richmond Street and is best oriented for out-of-town visitors by recalling that it runs along the south side of Simpson's store.

States Mr. Reed: "There was certainly one (hospital) in connection with Fort York (now the Old Fort at the 'Exhibition Grounds'), for in an old plan of 1816 a hospital and a house for surgeons is plainly marked on the banks of the old Garrison Creek, about the northwest corner of the present King and Tecumseh Streets (Robertson's *Landmarks V*, pp. 293-5). This would indicate that a similar hospital had existed before the War of 1812 and was likely demolished by the American army at the capture of York, 27th April, 1813."

#### Wounded Evacuated to York

A clear picture of the medical arrangements in connection with the Niagara campaign of 1814 and that period generally is given in *Medical Topography of Upper Canada* by John Douglas (1788-1861) who was Assistant Surgeon to the Eighth Regiment:

"The active services of the troops were continued for a period of nearly three years. The campaign of 1814, which preceded the ratification of peace in the following spring, was rendered important by the successful achievements of the army. Being stationed at York in charge of the general hospital during the greater part of that year's campaign, a favourable opportunity was afforded me of witnessing the state of the sick and wounded who were sent thither from the army. That part of the province, I may observe, which stretches from Fort George to Fort Erie was the principal field of active operation. After the several actions which were fought in that tract of the country, the wounded were immediately conducted to the rear as far as Fort George, from whence they were shipped on board small vessels, conveyed across the western extremity of Lake Ontario, to be landed at York, and admitted into hospital. On the evening of the second or third day after an action, they generally reached their place of destination. After the battle of Chippewa, which took place on the 5th of July, a considerable number of wounded were disembarked at York, and admitted into hospital. Sufficient accommodation being afforded them, the routine of medical duty had not as yet met with any obstruction. The battle of Lundy's Lane, which was fought on

the 17th of the same month, being more sanguinary than that of Chippewa, filled the general hospital at York, and its adjacent buildings, with its numerous wounded. After the latter period, the duty of the medical department, not only at York, but along the Niagara frontier, became serious and laborious. The skirmishes and casual engagements which occurred during the remainder of the campaign, kept the hospitals more or less filled with wounded till the beginning of winter, when the enemy, evacuating Fort Erie, passed over the river Niagara to the peaceful possession of his own territory. Our troops, though opposed to a force much greater in number, generally maintained their ground; and in almost every encounter had the scale of victory in their side. The task, however, is not mine either to applaud the well-conducted enterprises of an army, or to censure those precipitated measures, which, in their fatal consequences, often obscure the brightest prospects of success."

He then describes the "general hospital" and how it became necessary to convert the Church at York into a temporary hospital. This little church (see illustration) was the early precursor of what later became St. James' Cathedral, which has continued over the years to be one of the finest edifices in that "city of churches". Incidentally the offer was made by the "missionary" at York, the Rev. Dr. John Strachan, better known to succeeding generations as Bishop Strachan. Writes Dr. Douglas:

"The general hospital at York, though a commodious building, was deficient in size for the accommodation of the sick and wounded. Its apartments being originally intended for family use, were too small for the wards of an hospital, and did not admit of a free ventilation. Neither were the adjoining houses of the hospital, which were fitted up for temporary accommodation, any way suitable for the reception of the wounded. When, in the course of the summer the wounded became so numerous as not to be contained within the general hospital and its outhouses, the church, a large and well-ventilated building, was dismantled of its seats, and, for the time being, converted into an hospital."

The chief virtue of the church would seem to have been its air-conditioning, although it is not stated whether this was due to the higher ceiling or to poor fitting of the windows:

"The wounded who were admitted into the church hospital had all the advantages of a free ventilation. This building became extremely serviceable to the recovery of those men whose injuries were of a serious kind. From the pure air which the sick and wounded enjoyed in it, their progress to a state of convalescence was often rapid. Men

whose wounds put on an unpromising aspect in the general hospital, were at times transferred to this establishment. Intermittent fever, however, with all its fatality, prevailed in the latter, as well as in the former building."

#### "Tiger" Dunlop at York

In the late summer or early autumn of 1814 Dr. William Dunlop, Assistant Surgeon to the 89th Regiment, was moved from Queenston, then in ruins, to York in order to take charge of some thirty of his men "in general hospital in that garrison". (Dr. Dunlop is better remembered as "Tiger" Dunlop and as author of the blunt and eccentric will described in the July, 1943, issue of *The Canadian Hospital*.)

He, too, was an author, and in his *Recollections of the American War (1812-1814)* wrote:

"Toronto was then (1814) a dirty straggling village, containing about 60 houses. The church—the only one—was converted into a general hospital, and I formed my lodge in the wing of the Parliament buildings which has escaped, when the Americans had burnt the rest of that fabric.

"Our accommodations were comfortable, by comparison with what we had lately been obliged to put up with. At all events, we had a tight roof over our heads, a clean floor under our feet, and the means of fire enough to keep us warm; and a soldier who is not content with this, on a campaign, deserves to want."

Three years after the close of the war (1817) it became obvious that a proper hospital was needed and in 1818 the Government set aside some 393 acres of land in the town for its endowment. Some of these lands are still held by the Trustees of the Toronto General Hospital. In 1820 a two-storey building, 107 by 60 feet, was begun, with outbuildings for patients suffering from cholera, fever and other communicable diseases. Still uncompleted in 1824, the building was hastily converted into a legislative building when the five-year-old Parliament Buildings were destroyed in a Christmas Eve fire. Not until the new Parliament Buildings were completed five years later was it possible to use the building for its original purpose.

Hospitals are an evidence and a measure of the extent of our social progress. — *The Honourable George A. Drew.*

*We are indebted to Mr. T. A. Reed of the University of Toronto, the noted authority on the history of Southern Ontario, for much of the material in this article.*

# Preliminary Steps Being Taken to Combat Another Epidemic

**I**F influenza or any similar epidemic strikes Canada as it did in 1918-19, efforts are to be made to so mobilize doctors, nurses and others and to set up such emergency facilities that the harrowing experiences of those days can be considerably minimized. The health facilities of the whole country are to be so organized that the neglect and confusion of the last epidemic need never occur again.

This was the decision at a two-day conference on epidemics held in Ottawa in December. Organized by the Canadian Medical Association with the co-operation of the Department of Pensions and National Health, the C.M.A. Committee on Epidemics under Dr. T. H. Leggett called together representatives of public health departments, the medical profession, nurses, hospitals, volunteer workers, national women's organizations, labour, the Red Cross, the St. John Ambulance Association, the Armed Forces and other organizations. Miss Marion Lindebergh and Miss K. W. Ellis represented the C.N.A. and, owing to the illness of the President, the Canadian Hospital Council was represented by its Secretary.

## Tropical Diseases

While most interest centred about influenza, much thought was given to other diseases, usually considered tropical, but breaking out occasionally in Canada and now more likely to occur with the large numbers of uniformed men and women exposed to these conditions in foreign theatres of war.

It is not generally known, for instance, that malarial outbreaks occurred during the building of the Rideau Canal and that, at one time, malaria was rampant in the Niagara Peninsula. The *anopheles* mosquito which carries malaria is found in nearly all parts of Canada; Dr. H. M. Speechly of Winnipeg reported an intensive study of mosquitos in

this area in which it was found that 20 per cent were *anopheles*.

However, thanks to the careful control of the situation at port quarantine stations, to close studies being made by public health laboratories and the medical services in the Armed Forces, to the absence of certain "vectors" or intermediary hosts, and to the protection of natural climatic conditions, such diseases as malaria, bubonic plague, yellow fever, dengue fever, leishmaniasis (kala-azar), trypanosomiasis, bilharzia, ancylostoma (hook worm), etc., are not likely to gain any permanent foothold in Canada. Interesting reviews of these diseases were given by Brig.-Gen. J. C. Meakins, A.D.G.M.S. (Army), C. P. Brown, M.D., Chief, Division of Quarantine, D.P.N.H., and G. D. W. Cameron, Chief, Laboratory of Hygiene, D.P.N.H.

## Influenzal Epidemics

The said story of 1918-19 was related by Dr. J. J. Heagerty, Director, Public Health Services, D.P.N.H. (See article). Whether or not the present mild epidemic so prevalent in eastern cities is caused by a similar virus is not known because of lack of proper identification in 1918-19. There was expressed a general concern, however, that during these later war years, or in the immediate post-war period, a somewhat similar outbreak might occur. The build-up now of mild epidemics is not dissimilar to the picture in 1916 and 1917.

Various speakers stressed the need

for careful organization now. The shortage of doctors and nurses, the present overcrowding of hospitals in larger centres, the unusual crowded home conditions of war workers, the lack of hospitals for convalescents or chronic patients, the lack of non-nursing personnel for either hospitals or private homes—all indicate the need for serious planning without delay.

## Provincial Organization

Prior to the Conference, the Canadian Medical Association had named the chairmen of provincial committees and these chairmen participated in the meeting. They are as follows: *British Columbia*

Dr. G. O. Matthews, Vancouver.

*Alberta*

Dr. W. H. Hill, Calgary.

*Saskatchewan*

Dr. Arthur Wilson, Saskatoon.

*Manitoba*

Dr. H. M. Speechly, Winnipeg.

*Ontario*

Dr. Beverly Hannah, Toronto.

*Quebec*

Dr. A. R. Foley, Quebec City.

*New Brunswick*

Dr. V. D. Davidson, Saint John.

*Nova Scotia*

Dr. P. S. Campbell, Halifax.

*Prince Edward Island*

Dr. B. C. Keeping, Charlottetown.

These provincial chairmen are to organize their provinces in full co-operation with the provincial and municipal departments of health, and to work with the medical, hospital and nurse associations, voluntary organizations, urban and rural women's societies, labour groups, the Red Cross and other bodies.

Particularly helpful was the report of Dr. Speechly's Manitoba committee which has already completed its outline of action.

(Concluded on page 60)

## Two Tons of Turkey Basis of Webb Hall Dinner

The New Year's Day dinner at Webb Hall in Toronto was one of the largest military dinners ever served in Canada. Nearly five thousand soldiers cleaned up 250 turkeys, weighing approximately two tons. In addition there disappeared 15 bushels of sweet potatoes, 700 mince pies and 300 gallons of tea. No figures were

released on the grape fruit, green peas, celery, olives, Christmas cake, oranges, nuts, grapes, etc.—or the number on sick parade next day.

Messing officer in charge was Captain Arnold Taylor. Captain A. H. Ferry, welfare officer, arranged an excellent entertainment programme.



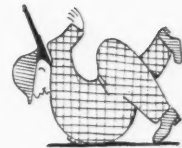


## *An Army Marches*



*Photographs courtesy  
Army Information Bureau.*

*Glimpses of the 7000-  
capacity kitchens at  
Webb Hall (Army),  
Toronto.*



## *On It's Stomach*



# Obiter Dicta

## The Epidemic Situation

THE most striking illustration of the possibility of an influenza epidemic was provided by the roll call of representatives at the December Conference on Epidemics held in Ottawa. Quite a number of the original representatives named had to send substitutes because they were incapacitated by the present mild epidemic of "grippe", so wide-spread in various eastern centres. Despite soothing statements to the contrary, both history and present experience indicate that we should lay plans now for emergency action. As in the case of A.R.P., it is wise to be prepared even though it never be necessary to throw our machinery into action.

From the viewpoint of hospital care, we have every reason to be apprehensive of our ability to handle a serious epidemic. Two years ago a survey revealed 7,200 beds available with another potential 5,200, if solarium, corridors and unused space were utilized. Today, except in some small centre locations, every hospital bed is filled and, in the congested areas most likely to require extensive hospitalization, the hospitals are taxed beyond their capacity. Moreover, even if space and beds be available, it is improbable that the hospital personnel could handle the situation, decimated as it too would be at that time. The lack in most communities of any convalescent facilities or of hospitals for chronic diseases would hamper considerably the evacuation of the less acute patients.

Despite these handicaps we must work out the best possible solution. Extra space can be found, if not within the hospital, then in school houses, college residences, or elsewhere. Beds and linen may be obtainable from government sources; we know that large amounts have been held in reserve in case of air raids or disaster. Non-urgent surgery can be discontinued. Every effort can be made to evacuate subacute cases. Women's organizations, through Mrs. Hardy, Mme. Marchand, Mrs. West and others assured the Conference that they would make every

effort to provide voluntary assistance to take the load off the nursing staff; the Red Cross and the St. John Ambulance Association have agreed to help in every way possible. In large cities, a central office for admitting and steering patients can be set up. Cities can be zoned for medical calls to save the doctors' time. Volunteer drivers and delivery truck ambulances can be organized. The Canadian Nurses Association will endeavour to put married and retired nurses back into uniform. One of the greatest needs will be for substaff.

Now is the time to get organized. It is anticipated that the hospital associations will be asked to participate in the work of the respective provincial committees. It is particularly important that this participation be an active one, for the hospitals by their very function must occupy a key position in any programme developed.



## The Shortage of Residents

ONE of the many difficulties created or aggravated by the war has been that of a shortage of senior interns and residents. Practically all of the larger hospitals, normally able to obtain an adequate number of residents, are now finding themselves down to a bare minimum and in many cases must depend entirely upon junior interns. This is particularly serious in the case of teaching hospitals, where considerable responsibility for the selection and arrangement of clinical cases normally rests on the resident. Many hospitals are dependent upon men who are physically unfit, or upon women. Younger men in practice have helped to undertake some of these responsibilities, but now most of the junior attendings are either in uniform or are already carrying a double load. The situation has been relieved slightly in some hospitals by releasing enlisted men for short periods, largely to get special training in selected fields, but this

procedure, helpful though it has been, has not begun to meet the situation.

A promising arrangement has been effected in the United States. The Directing Board of the Procurement and Assignment Service and the Surgeons General of the Army and Navy have worked out a "9.9.9." basis as follows: the internship will be nine months; one-third of the interns holding commissions in the Army and Navy may then be deferred for nine months more (junior residency); one-half of this number, or one-sixth of the total, may be deferred for an additional nine months (senior residency). This plan is subject to agreement by the state licensing boards to recognize the eligibility of these interns for licensure. Hospitals may be placed upon a quota basis.

Here in Canada, where the present internships are on an eight months' basis, the Canadian Medical Association has taken active interest in this situation. Its Executive Committee has requested that 10 per cent of the interns in uniform be permitted to remain for a further period of eight months. Although there is a serious need for more medical officers, this would mean but an eight months' lag in the availability of 40-50 men and this would be compensated for by their better training. The Canadian Medical Procurement and Assignment Board has since recommended that the Services give sympathetic consideration to this request. This would be of considerable help to the hospitals.

A factor not to be overlooked, however, is the attitude of the interns themselves. Most young men with red blood in their veins are itching to get into active service and some, despite their desire to gain further training, do not feel that they would care to remain that much longer out of the army. The question of pay, too, would come up. Would they like to continue on at privates' pay, while their companions gain commissions and officers' pay? Would the Armed Forces be willing to let them receive an added honorarium from the hospital? As an increasing number of senior students and interns are getting married, this factor of finance is of importance.



### The Health Insurance Situation in Ontario

UP TO the time of preparing this issue of *The Canadian Hospital*, no definite announcement had been made by the Ontario Minister of Health with respect to the details of the hospital insurance legislation which will be introduced, it is anticipated, at the forthcoming session of the Ontario Legislature. Considerable publicity, in large part of a speculative nature, has appeared in the press, but it is obvious that the Government is not making any definite commitment with respect to details until certain studies, now under way, will have been completed.

During November and December a group of hospital and departmental accountants collected and analysed cost figures from a large group of representative hospitals. This study is designed to give the government an accurate picture of the actual cost of providing various hospital

services in hospitals of different sizes and types. Obviously, if the government is going to underwrite the cost of hospital care, as was promised at the convention of the Ontario Hospital Association, the present grant and payments will need to undergo considerable upward revision, particularly in the case of those hospitals with more complete services.

During the month of December a sub-committee of Mr. Swanson's Hospital Committee, under the chairmanship of Mr. Norman Saunders, made a study of the hospital needs of various portions of the province. The purpose of this particular study has been to ascertain the extent to which existing hospital facilities meet the needs of various communities. It is known that in most areas, particularly industrial areas, the general hospitals are overcrowded. This is especially true of some of the services and types of accommodation. This study, which is being made of all parts of the province, should give more exact information than has yet been obtainable. In addition it is hoped to obtain a fairly accurate picture of the shortages in the various areas of hospitals of special types, such as hospitals for the incurable, for the chronically ill, convalescents, those requiring isolation, etc. The Hon. Dr. Vivian very rightly has felt that no announcement should be made by the Government as to the details of any hospital plan offered without having some clear information as to the ability of the hospital field to handle the increased demands upon hospitalization facilities which can be anticipated under any province-wide plan of hospital care.

That the Government intends to introduce some form of obligatory hospital insurance at the forthcoming session seems obvious, but up to the present at least no statement has been issued indicating whether the cost would be underwritten by an obligatory payment by each adult, supplemented by governmental assistance, or whether the whole cost would be paid out of the consolidated revenue of the Province. It would appear that the hospital field is hoping that the financial arrangement will be through personal premiums, in part at least, for the financing of such a major project entirely from state funds would place the entire hospital system directly under the state.

There has been some speculation in the newspapers as to whether or not the Government would confine the initial operation of this plan to certain selected areas or counties. It may be that the lack of adequate hospital facilities in some areas may prevent the immediate extension of such a plan to these areas, but up to the present no announcement has been made by the Government.

Some speculation has taken place also as to whether or not the Ontario proposal is designed as a rebuff to the Federal Health Insurance proposal. As the Minister has stated on several occasions that it is the intention of the Ontario Government to introduce additional phases of health insurance in subsequent sessions, supplementing the introduction this year of hospital care, it would appear that the fundamental difference between the Provincial and Federal proposals is largely that in one case the approach would be a gradual one, whereas in the Federal proposal the measure would provide a complete plan of health care in one enactment.

## Venereal Disease Control Conference

By LT.-COL. D. H. WILLIAMS, M.D.,

Chief, Division of Venereal Disease Control,  
Department of Pensions and National Health

THE seriousness of the venereal disease situation in Canada has recently aroused the general interest of the public and their governing agencies. The need was recognized by all for the earliest implementation of action to reduce the threat of venereal infection to Canada's war effort and to Canada's home life. On July 1st, 1943, a comprehensive control programme was launched. This effort, initiated by the Army, integrated the control measures of the Navy, Air Force, Department of Pensions and National Health, and Provincial Health Departments.

Appreciative of the importance of co-ordinating and unifying the control measures of all interested agencies in Canada, the Minister of Pensions and National Health called a National Venereal Disease Control Conference in Ottawa, December 6th-9th. At this meeting 105 delegates and visitors assembled. (See Dr. Piercey's report.)

The purpose of the conference was to consider how best the existing administrative facilities for the prevention of venereal disease could be utilized in Canada; and what need existed for modification and extension of these facilities. As a result of the deliberations of the conference, guided by the wisdom and experience of visitors from the United Kingdom and the United States, the basis of a National Venereal Disease Control Programme was laid down. Principles and policy which would guide this programme were approved. Definite specific types of preventive action and the spheres within which

this action was to be taken, were determined.

### A Four-Sector Front

A charter to guide the Canadian venereal disease control effort on a comprehensive basis was approved. This charter interpreted Canada's response to the threat of venereal infection as envisaging a four-sector Canadian Front against venereal disease. These are the HEALTH, WELFARE, LEGAL and MORAL SECTORS—components of an indivisible whole aligned against a common foe. The ultimate objective is to destroy syphilis and gonorrhoea. The purpose of each sector is to take the offensive with the weapons peculiar to its own method of attack. Waging unrelenting war on the Health Sector with weapons of modern medical science and public health procedure, will be physicians, nurses and Health Departments. Leading the attack on the Welfare Sector will be found social workers and welfare agencies armed to battle squalor, overcrowding, lack of food, neglect and insecurity. Directing a vigorous action on the Legal Sector will be the courts, the legal profession and police agencies whose action seeks out and brings to justice those who for personal gain purvey to men's weaknesses. On the Moral Sector the battle is to be led by the churches and homes of Canada, strengthening the moral fibre of our nation and upholding the security of marriage and family life. Each sector has its own territories, its own personnel and armaments. The ultimate objective is the same.

### Health Sector

A six-point strategy on the Health Sector was adopted by the National Conference:

#### 1. Health Education

The facts concerning V.D. will end the conspiracy of silence, banish outworn fallacies, and remove false fears. Lectures, motion pictures, posters and pamphlets will tell the story of how V.D. may be vanquished.

#### 2. Medical Care

Every Canadian who requires examination and treatment should have the best that medical science can provide. Free blood tests, free drugs and free clinics are being provided by Health Departments. It is cheaper to cure and prevent V.D. than to pay taxes for the end results of neglected infection.

#### 3. Abolition of Quackery

Laws exist in Canada to protect citizens from the quack and charlatan. Only qualified physicians are permitted by law to care for those suffering from V.D. The public must be protected from the incompetent and the rogue.

#### 4. Prenatal Blood Tests

Every expectant mother must have a blood test for syphilis before the Fifth Month. Demand it! Insist upon it! It is the only protection many unborn children have.

#### 5. Premarital Blood Tests

Health examinations, including blood tests, are a safeguard against the sinister encroachment of syphilis on home and family life.

#### 6. Contact Investigations

Careful search must be made for all who have been contacts to known V.D. Only by seeking these people and by bringing them under medical supervision can the extending network of V.D. be destroyed.

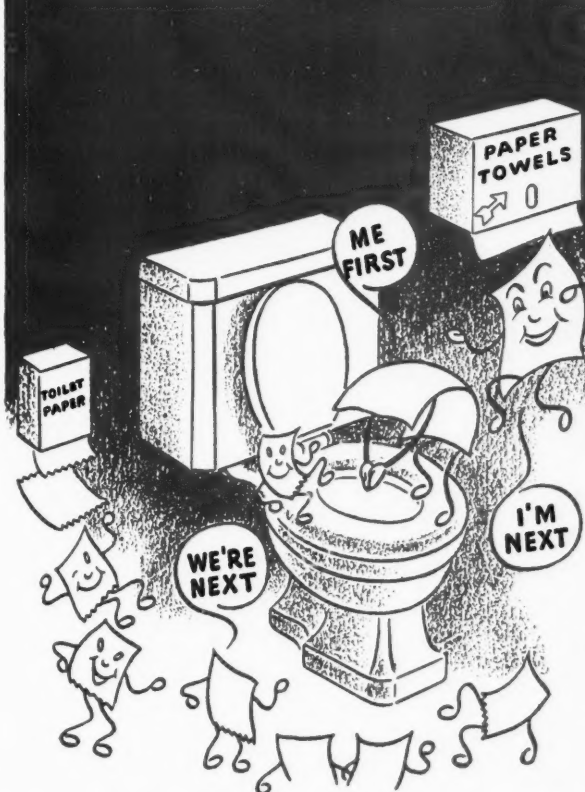
Today, as never before, events and conditions are favourable for the final eradication of the venereal diseases in Canada. The urgency of removing this threat to the health and efficiency of the Armed Forces is recognized by all. There is a full tide of wholesome public interest, concern and support for measures

(Concluded on page 40)

# HYPRO Interfold Toilet Seat Covers

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# Comments

## On the First National V. D. Control Conference

By **W. DOUGLAS PIERCEY, M.D.**,  
Supt., Ottawa Civic Hospital

A CONFERENCE which should go a long way towards the control of venereal disease in Canada was called at the request of the Honourable Ian Mackenzie, Minister of Pensions and National Health, Ottawa, on December 6-9, 1943. The Department of Pensions and National Health is to be congratulated on the well-prepared agenda which, along with a wise selection of speakers, assured the success of the conference from the outset. Lt.-Col. Williams discusses the highlights of the programme elsewhere in this issue. At the last regular session of the Conference many resolutions were passed, and if the majority of these can be carried out the control of venereal disease in Canada is assured.

### Delegates

Delegates were present representing the various divisions of the Department of Pensions and National Health, the Navy, the Army, the R.C.A.F., the Department of Indian Affairs, the Department of Trade and Commerce (Vital Statistics), the Provincial Departments of Health, Department of Health representatives from nine leading cities, and the Departments of Preventive Medicine from eight universities. The Canadian Hospital Council, the Canadian Medical Association, the Health League of Canada and other bodies were well represented. (Dr. L. P. Ereaux of Montreal and Dr. W. D. Piercey of Ottawa represented the Canadian Hospital Council.)

The United Kingdom was represented by distinguished members of the Royal Navy, the R.A.M.C., the R.A.F., the British Ministry of Health and the Medical Research Council. The United States was well

represented by the Venereal Disease Control Officers of the Army and Navy, and members of the U.S. Public Health Service, the National Research Council and the American Social Hygiene Association. Australia was represented also.

### The Sessions

The four days of sessions provided much opportunity for a free discussion of the many aspects of the venereal problem. Recent advances in diagnosis and treatment were reviewed. Educational media, including the press, the radio, the motion picture, posters and pamphlets were considered.

At one evening session the conference divided into committees on (1) Administration; (2) Records and Statistics; (3) Diagnostic and Therapeutic Procedures; (4) Epidemiology and (5) Education.

Three educational films were shown at one of the evening sessions. These were a recent British film for lay audiences, "Fight Syphilis", a film on the community aspects of venereal disease control issued by the United States Public Health Survey and "syphilis", a three-reel coloured sound film for the medical profession. On another occasion three other educational films on V.D. control were shown.

On the third day meetings of the special committees continued and in the afternoon the conference divided into sectional committees of (1) Armed Forces Medical Services delegates; (2) civilian Federal, Provincial and Municipal delegates and (3) University Departments of Preventive Medicine delegates.

On the final morning the conference re-assembled as a whole, when resolutions were presented to the

conference by the various committees and sections.

The luncheon sessions were an important part of the conference, during which many of the visiting delegates presented various aspects of venereal control being attempted in Great Britain and the United States.

### An Opportunity

"Perhaps the most effective approach to creating new and lasting friendships in the present emergency is through the hospitals' relationships with the thousands of temporary voluntary workers who are coming into the field to replace professional and semi-professional workers who have left or to complement the work of those remaining.

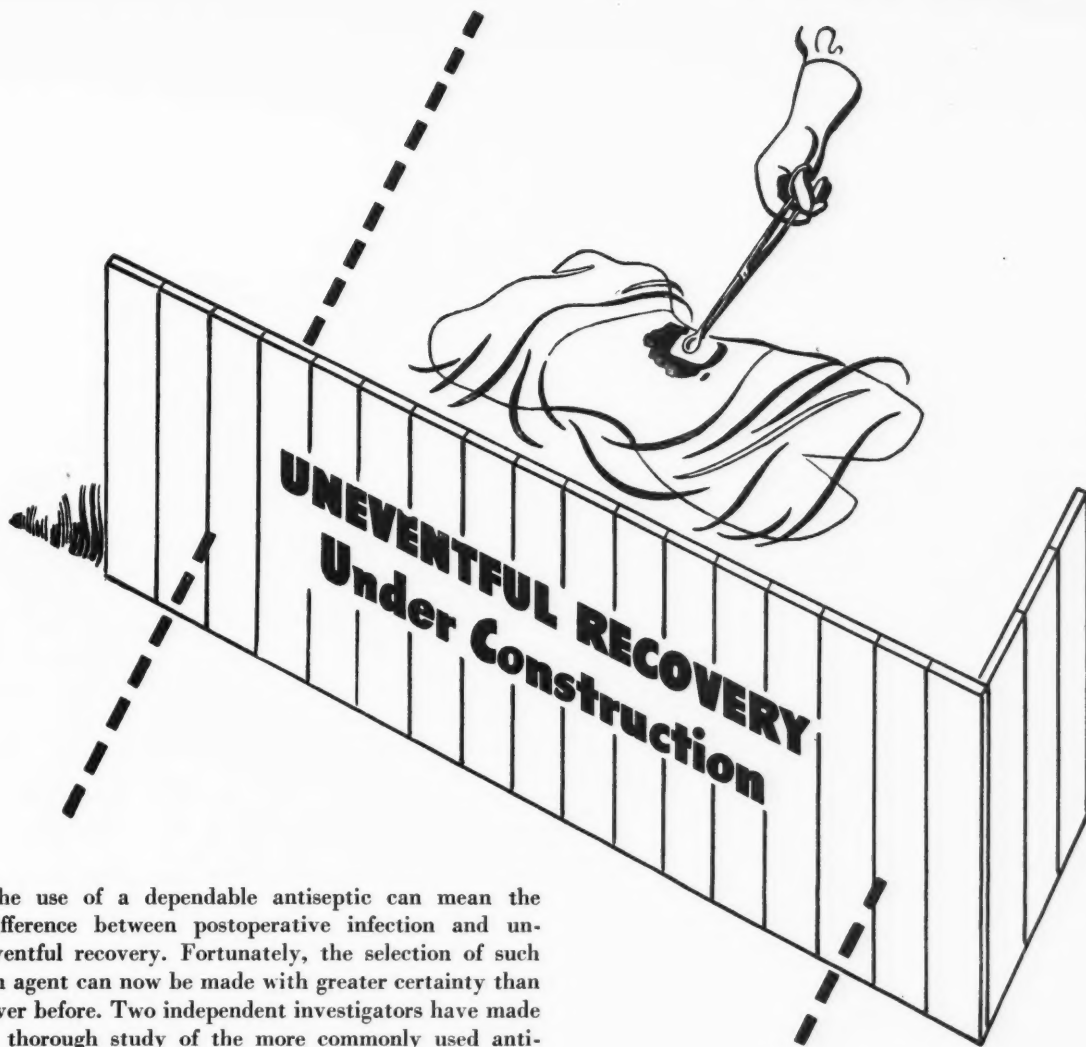
"The voluntary lay personnel now being brought into the hospital service activity to fill a temporary gap should be considered more than simply patriotic individuals and willing workers with whom we are for the moment burdened. Such volunteer workers, we must recognize, are essential to our continued effective operation for some time to come. Therefore, there is imposed upon us a responsibility to see not only that they are properly trained for present duties but that the hospital and its activities are so interpreted to them that in the days to come they will go back to their circle of acquaintances with a broad concept of the hospital as the life-saving station of the community and an indispensable agency of community welfare."

*Carl I. Flath in "Modern Hospital".*

**Lt.-Col. D. H. Williams**  
(Concluded from page 38)

directed against these master saboteurs of war effort. Never before has there been such an imposing show of force representing all the available human resources arrayed against the serious threat of syphilis and gonorrhoea.

If every citizen in Canada takes his battle station on the Health, Welfare, Legal or Moral sector of Canada's four-sector front against venereal disease, the favourable outcome of the battle is assured and the purpose for which the National Venereal Disease Control Conference was called will have been fulfilled.



The use of a dependable antiseptic can mean the difference between postoperative infection and uneventful recovery. Fortunately, the selection of such an agent can now be made with greater certainty than ever before. Two independent investigators have made a thorough study of the more commonly used antiseptic agents and have published a complete report of their findings.\* *Tincture Metaphen was designated the most effective agent tested.* On the oral mucosa, Tincture Metaphen 1 : 200 was found to reduce bacterial count 95% to 100% within five minutes; to have, in substantial excess over any other antiseptic agent tested, a duration of action of two hours; and to produce only slight irritation in some cases, none in others. Metaphen does not appreciably precipitate blood serum; does not affect surgical instruments or rubber goods; and is quite stable when exposed to air in ordinary use. If you are not already using Tincture Metaphen 1 : 200, give it a trial. It is available in pharmacies everywhere in 1-ounce, 4-ounce, 16-ounce and 1-gallon bottles. ABBOTT LABORATORIES, LIMITED, 20 Bates Road, Montreal.

\*Meyer, E., and Arnold, L. (1938), Amer. J. Digest. Dis., 5: 418.

## Tincture Metaphen

(Tincture of 4-nitro-anhydro-hydroxy-  
mercury-orthocresol Abbott)

# With the Hospitals in Britain



C. E. A. Bedwell

Dear Mr. Editor:

In the course of reconstructing the government the Prime Minister has taken the opportunity to make a change at the Ministry of Health. Mr. Ernest Brown, as was generally expected has gone and in his place Mr. Churchill has appointed Mr. H. U. Willink, K.C., who has only been a member of the House of Commons for a little more than three years. He did admirable work as the Special Commissioner to supervise arrangements for the care and rehousing of people made homeless by air raids in the London Civil Defence Region. More recently he was chairman of a special committee appointed to advise the government upon an agitation that women should be entitled to the same compensation as men for war injuries. The committee presented such a convincing report that the government at once conceded the claim. Mr. Willink has some association with the medical profession as he is the son-in-law of Dr. Morley Fletcher the well known physician. Not the least of his qualifications for the post at the present time is that he has a trained legal mind, for in the re-organization of the health services there are conflicting claims to be reconciled in which a judicial attitude will be of inestimable advantage.

## Two Important Reports

The promised government statement for the information of public opinion and the consideration of interested parties is still on the horizon. In the meantime the number of important documents to be studied continues to accumulate. The latest additions are two valuable reports from the Royal College of Physicians. The first deals with the subject of social and preventive medicine and recog-

nizes that the medical profession is being led forward "to accept the idea of the preservation of health as its primary function". That will involve considerable changes in the medical curriculum. It is admitted that the course in preventive medicine in the passage of years has become much more complex in content "and is now

## Royal College of Physicians urges medical teaching closer linked to social needs.

a hotch-potch of seemingly incongruous ingredients". In making their suggestions the Committee point to the example of Canada in presenting social medicine as a background throughout the whole of the curriculum extending over the clinical years.

In considering the organization of the Department of Social and Preventive Medicine it is laid down specifically that it is the function of the Head "to demonstrate the principles that underlie the work of a health centre and its relation to hospitals on the one hand and to the health authority on the other". Anticipating the development of health centres on a wide scale the Committee consider that "the medical student should come to regard them as a focal point of his studies in preventive medicine and should be as familiar with their work as he is with the out-patient department of a teaching hospital".

It is clear that every medical school will have to establish a Department of Social and Preventive Medicine as recommended by the Committee, in which, in addition to the proposed changes in the curriculum, the student health services should be used as an instrument of teaching. All medical schools should also recognize the importance of problems connected with industrial medicine.

By "LONDONER"

Finally, the Royal College expresses its intention of taking an active interest in the organization of the teaching of social and preventive medicine not only to medical students but also to nurses and medical social workers.

## Psychological Medicine

The second report deals with the teaching of psychological medicine and argues that the experience with the health of men in the Forces has shown the shortcomings of the existing methods of education, which tended to regard psychiatry as a specialty not to be meddled with by the practitioner. Now the deans of medical schools have been asked to amend the undergraduate course so that newly qualified doctors would be better able to deal with common psychiatric problems. The report carefully considers the scope of the teaching of psychiatry and in particular its relationship to social medicine. It states: "psychiatry is concerned with the behaviour of human beings in their environment; in its methods of study and treatment it never deals with the intricate unique individual as though he existed in a vacuum or in a standard milieu, any more than the practitioner intent on social medicine overlooks the variation from man to man which causes the same social influence to bring about such different effects. Psychology and social medicine have been described as the inside and the outside of the same glove and in the teaching of the medical student they must be closely associated".

## Presidential Summing-Up

Lord Moran, the President of the college, followed up the publication of the reports with an admirable letter to *The Times*. He answered the contention that the proposals would be overloading the curriculum by saying: "We are not adding a new set

(Concluded on page 58)



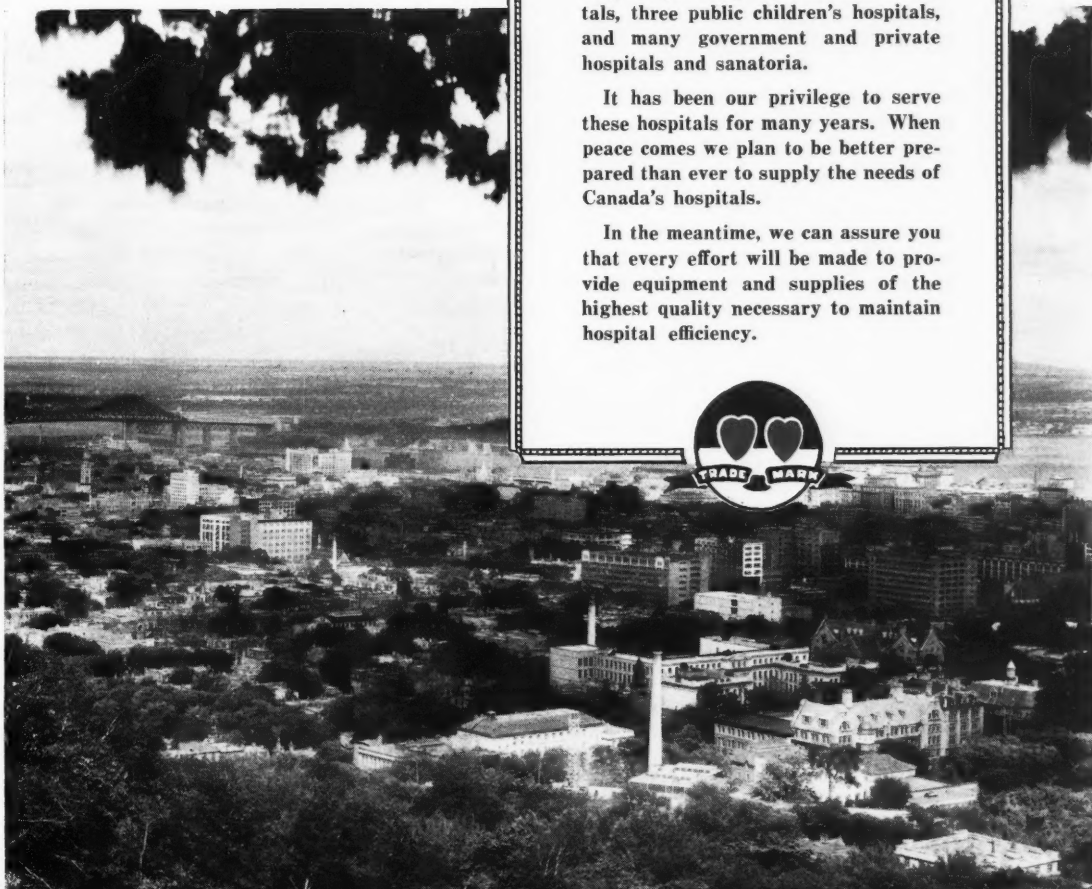
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### **Mental Patients with Tuberculosis** (Concluded from page 31)

that it may be cleansed and receive the care indicated. They are also asked to report any severe or prolonged cold or symptoms suggestive of chest disease; to exercise care in handling sputum cups and cup holders; to keep their hands away from infected material as far as possible; to wash their hands frequently and thoroughly while on the ward and to keep their hands away from their mouths; to wash their hands after leaving the ward and especially before eating. They are warned never to eat food on the wards. In addition to the strict attention to masks and gowns, they are warned to avoid as far as possible getting close to patients' mouths or getting their direct breath or the droplet spray when the patient coughs. They are also advised to try to maintain their immunity by attention to their general health. These precautions mentioned so far are what is expected of the individual member.

The precautions taken by the Administration in the interest of the staff are:

(i) Only positive reactors over twenty-one years of age are employed;

(ii) A complete chest x-ray survey of all staff is carried out every three to four months, ensuring that disease if it is present will be discovered in the earliest possible stage; in any case suspected from x-ray of having tuberculosis a complete chest examination is performed and, if indicated, re-examination and repeat x-rays are done in one or two months;

(iii) Anyone noticed from the monthly weight record to be losing weight steadily or showing gross loss is interviewed and, if indicated, chest investigation is carried out;

(iv) If one is found to have a severe or prolonged cold, a complete chest investigation, including x-ray, is done.

At each of the Ontario Hospitals, apart from the tuberculosis unit, male and female chest observation wards are provided for the care and investigation of patients with suspected or questionably active pulmonary tuberculosis. The precautions taken by staff in attendance on these wards are essentially the same as those outlined for the tuberculosis unit.

### **Case Finding Programme in Service**

A discussion on this subject would not be complete without some reference to the case finding and general anti-tuberculosis programme as it exists in the Ontario Hospital Service.

In 1930 the Division of Tuberculosis Prevention in conjunction with the Ontario Hospitals Division began investigations to determine the extent of tuberculosis in Ontario hospitals and to arrange for the necessary segregation and treatment. At first patients with suggestive symptoms were x-rayed, then temperature surveys, blood sedimentation rate surveys, tuberculin test surveys and so on were tried, in order to find cases indicated as requiring x-rays. Each method yielded a few cases of active disease, but none was really adequate. In 1936 a fluoroscopic survey of more than 1,200 patients in one hospital revealed, with x-ray confirmation, that (in spite of the previous removal of active cases by the combining with the previous case finding methods) 2 per cent had active disease and 2.3 per cent questionably active or suspect tuberculosis. That is, 4.3 per cent required isolation.

The following year, 1937, the programme as it exists to-day came into effect. This programme is supervised by the tuberculosis unit at Woodstock, to which all films are sent for interpretation and report. New patient admissions to any Ontario Hospital have a chest film taken as soon as possible after admission—always within one week. Once a year all patients and all staff (except non-reactors to tuberculin) have a film taken in the annual survey at each hospital, and in certain cases with questionable lesions, repeat films are taken after six months' interval, or sooner if indicated.

All new staff members who have had no tuberculin test and other staff members who have been non-reactors are tuberculin-tested at six months' intervals by the travelling clinician from the tuberculosis unit. Non-reactors do not have a chest film in the annual x-ray survey. If a non-reactor is found to have become positive, he has a chest x-ray immediately and is followed closely for at least one year, as it has been found that frequently following a change in

reaction, a lesion develops within a year.

In regard to patients' films, if active tuberculosis is diagnosed, the patient is transferred to the tuberculosis unit at Woodstock for treatment; if questionably active or suspect tuberculosis is present, the patient is isolated on the chest observation ward at the hospital concerned, and has further investigation, including sputum examinations, blood sedimentation tests, temperature and weight records, etc.; if apparently or probably arrested tuberculosis, old pleurisy, bronchiectasis or other pathology is demonstrated, the patient is recommended for casual observation as to chest disease while on the general wards, having sputum examinations, etc.

As for staff films, if tuberculosis or other pathology is revealed, the appropriate recommendations are made, such as further investigation or admission to sanatorium. Staff members with questionable chest x-rays are reviewed by a special chest board at the Parliament Buildings.

The post-sanatorium care of Ontario Hospital staff who have had treatment in sanatoria is supervised by the Division of Tuberculosis Prevention in very much the same way as the local boards of health provide care for residents of their municipalities, and the municipalities are relieved of this responsibility in such cases. The tuberculosis unit performs or arranges for re-examinations of such individuals every three or four months until they are able to return to part or full time duty, and continue frequent examinations after their return to duty, in an effort to prevent or forestall re-activation of disease.

### **Conclusion**

It is felt that advancement is being made in the fight against tuberculosis in the Ontario Hospitals and this, indirectly, is assisting in the control of tuberculosis in the province. The number of patients discovered to have active disease is less each year, and a larger proportion of the total each year are diagnosed while still in the minimal stage. With reference to staff, the number requiring sanatorium care is gradually decreasing and, in general, they are being discovered in earlier stages than they were a few years ago.

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# Here and There

## Our New Cover

COMMENCING with this issue, *The Canadian Hospital* will have a new cover. Our former cover has been satisfactory, has been distinctive and has met with general approval. However, it is nice, from time to time, to get new clothes, and the Editorial Board and the Publication Committee have felt that it would be timely to start the new year with a revamped cover design.

One advantage of the new cover is that the name of the magazine is now placed at the top of the cover rather than at the base. This will appeal to those readers who keep their magazines in vertical magazine-racks, in which the lower portion of the cover is concealed by the frame of the rack. The suggestion has been made from time to time that we should change the colour of the cover each month. Readers will recall that such a practice was followed for an experimental period several years ago, but it was found that some of the colours did not look very attractive, and it was finally decided to stay with the green. As a matter of fact the three leading hospital journals published in the United States consistently use yellow, blue and red.

Another innovation this month is designed to help those who pile their magazines horizontally. With the exception of certain special advertising numbers such as the March and October issues, it is not desirable to place the date of issue on the magazine end. However, readers will note on the squared end or back of this issue a small black square. Next month there will be two, and so on up to June, when there will be six. It is proposed that for July there will be a gap, followed by a seventh, and so on to the end of the year. By this easy means subscribers can glance at their horizontal pile of magazines and very quickly pick out the issue desired.

## Providing for Interns' Wives

An increasing number of young men graduating from medical schools are married at the time of graduation. In some classes this constitutes a large percentage of those graduating. In most instances the wives are expected to live elsewhere and some leniency is shown to these married interns in their coming and going. We have been interested in a letter which appeared in a recent issue of *Hospital Management*, written by Dr. Alan Craig, Medical Director of the Eastern Maine General Hospital at Bangor, an administrator well known throughout Canada as a former representative of the American College of Surgeons.

Dr. Craig writes that in his hospital the married interns have been provided with double rooms so that they and their wives could live at the hospital. The interns are housed in the old original hospital, which fortunately had a number of large rooms. They have been able also to provide these married interns with sitting rooms for themselves.

In most cases, also, the hospital has been able to employ the interns' wives either on the office staff or in some other capacity, in the nursing or other services. This has been very much appreciated, for in most cases the young couples have been financially embarrassed and welcome the additional income during the intern period. The net result has been a very happy relationship existing between the interns and the hospital.

\* \* \*

## These Modern Grannies!

They are telling the tale in an eastern city of an elderly woman whose health was such that she had to be kept on a very rigid diet. One evening when her daughter and her son-in-law were out, she rebelled against these restrictions and raided the ice box in proper fashion. By the time they returned the poor woman was paying the price for her rashness

## By The Editor

and it was obvious to the doctor called in that hospital care was necessary.

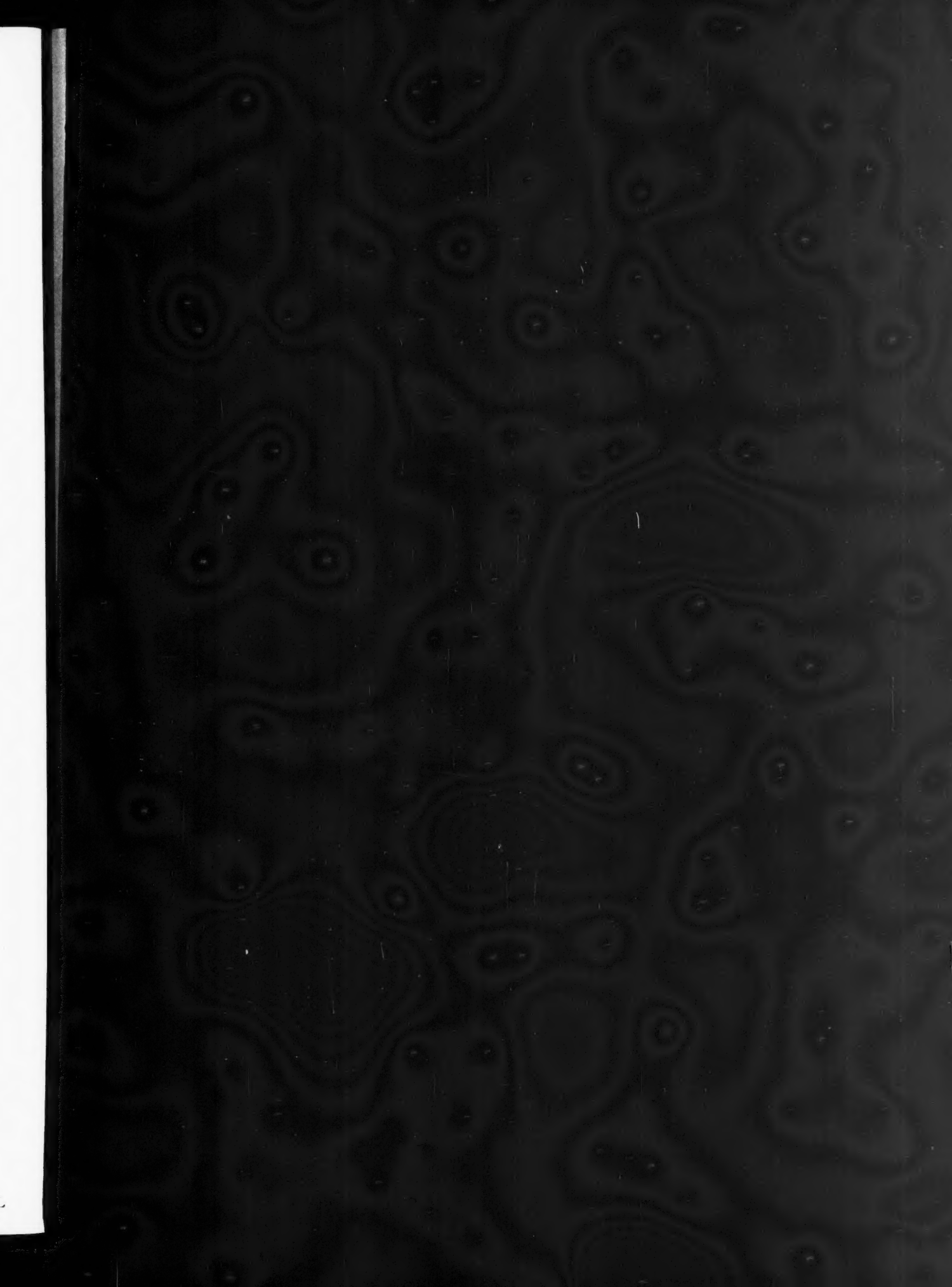
The little grandchild was much upset by the misfortune of her grandmother and next day after school decided to go to the hospital herself to see her granny. With everybody busy down there she actually got onto a ward—the obstetrical ward, as it happened—before she was accosted by one of the nurses. “I came to see my Granny”, she stated. “But I don’t think she would likely be in *here*”, replied the nurse. “Oh yes she is,” piped up the little maiden, and then shyly added by way of explanation as she wound one wrist about the other, “You see, Granny was naughty!”

\* \* \*

Dr. F. W. Gershaw, M.P., of Medicine Hat, tells of a record established by a homesteader in the amputation of a toe.

“A homesteader near here had his great toe badly frozen in a storm during March. The toe did not heal, as one might expect in such disease; it remained black and painful for many weeks. Eventually, fed up on the whole affair, he decided to do his own surgery and in his own way. What could be more fitting than his own trusty rifle? So he proceeded. His foot was placed carefully for support against a sack of oats at the foot of his bunk. He took careful aim and shot the toe off as clean as a whistle. However, Dame Nature like some other dames insisted on making trouble, and spoiled a perfectly good amputation operation by spilling around some streptococci and various other vicious things she keeps for the purpose. So his good intentions and inventive genius were wrecked and he had to be admitted to the hospital for treatment by an ordinary every-day surgeon like myself.”

(From the quarterly “*Historical Bulletin*”, issued by the staff of the *Calgary Associate Clinic*).





**TO**

*Surgeons in Service*

**ON THE WAR FRONT...**

**ON THE HOME FRONT**

When the history of World War II is written, the achievements of the surgical profession, both in the field and at home, will make one of its most noteworthy chapters.

Already thousands of fighting men for whom there would have been no hope in former wars, have been rescued by the skill of modern surgery, often under fire or other adverse conditions.

And in civilian life, thousands more owe their lives and health to surgeons giving of their skills and energies without stint.

Wartime surgical demands also have brought into practical service many valuable new surgical materials and techniques, to which Davis & Geck is proud to be able to contribute a substantial measure as the world's largest manufacturer of sutures.

Here at Davis & Geck we are working 'round the clock to maintain a constant supply of sutures for every type of military and civilian need. At the same time we are continuing steadily to advance Davis & Geck suture research and development.

**DAVIS & GECK, INC., BROOKLYN 1, N. Y., U. S. A.**

## ◀ Correspondence ▶

### Units of Credit Basis of Payment to Hospitals

(Michael M. Davis, Ph.D., Chairman of the Committee on Research in Medical Economics and Editor of "Medical Care", suggests a reserve of credit units for future activities.)

Dear Doctor Agnew:

As you know, I hope the unit scheme of payment can be tested out in the near future in Canada and perhaps here. It is promising. Many of the technical objections and difficulties which have been raised by various people can, I think, be adjusted.

An underlying difficulty with any system of units and credits is a tendency to crystallize procedure and even policy. It thus becomes more difficult to institute certain changes. Minor improvements which are within the framework of the accepted list of functions for which credits are given, are not interfered with. Suppose, however, medical or technolog-

ical discovery or a new community situation creates the need for revising the credits allocated to a certain function, e.g. x-ray, outpatient department, physiotherapy?

Or suppose certain hospitals want to undertake a new function which is not on the list at all; e.g. home nursing, shock therapy, or providing office space for the practice of staff doctors? Resistance will then appear from hospitals to a change in the credit system which would reduce existing credits for the more common functions.

The appraisal scheme for public health services established by the American Public Health Association has given evidence that this danger is real, even though in this case the credits have not been backed by financial payments.

One way of getting around this difficulty is to assign a certain number of credits (say 50 on your scale)

which would be kept unallocated to allow for new functions. Thus the policy would be established of anticipating progress, and for that end of having a kitty from which allowances of new credit allocations could be drawn. Thus allocations of credit for new elements in old functions or for entirely new functions could be made without reducing the credits for already accepted units. Revisions of the latter can and should be made only at long intervals. Thus hospitals that pioneer in new functions, or in important advances in old ones, would not be penalized for so doing; nor would the rank and file have any incentive to resist re-adjustments.

Sincerely yours,

"Michael M. Davis".

\* \* \*

### How Rumours Spread!

To the Secretary,  
Department of Hospital Service,  
Canadian Medical Association.

At a recent hospital convention at Vancouver, B.C., we have heard that you warned the Catholic Hospitals against the Blue Cross Insurance plan, but we did not get your objec-

## Have a "Coke" = Let's be friendly



*... the way to win a welcome wherever you go*

Where you find democracy, you find the feeling of friendliness. It's made up of little things that mark a way of life; sports, fair play, movies, and swing music. A phrase like *Have a "Coke"* turns strangers into friends, the same in both hemispheres. Around the globe Coca-Cola stands for *the pause that refreshes*—has become the high-sign of the good-hearted.

**"Coke" = Coca-Cola**

It's natural for popular names to acquire friendly abbreviations. That's why you hear Coca-Cola called "Coke."

# A Dermatitis Preventative



## <sup>GH</sup> Wood's Green Surgical Soap



... IS RECOMMENDED FOR  
USE IN HELPING TO PREVENT  
SKIN DERMATITIS

\* The Castile Soap with the Largest Sale to Hospitals

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**Correspondence**  
(Concluded from page 48)

tions. Would you kindly write and let us know what objections you have to the Blue Cross.

Very truly yours,  
"Sister \_\_\_\_\_",  
\_\_\_\_\_ Hospital,  
\_\_\_\_\_, Wash.

**Answer**

Your letter in which you state that you have heard that I have warned the Catholic hospitals against the Blue Cross insurance plans is a distinct surprise to me. As a director of our own highly successful plan in Ontario, I am a very strong supporter of the Blue Cross movement and feel badly that any remarks of mine should have been so misinterpreted or misquoted as to give a contrary opinion. I do not remember discussing the matter at all in Vancouver, but at the British Columbia Hospitals' Association meeting in Victoria I did discuss the possible effect of the compulsory plan of health insurance now under consideration in Canada on the voluntary hospital care plans. I quoted the opinion

of a prominent member of the Government Drafting Committee that if everybody were covered by health insurance, there would be little opportunity for the voluntary plans to continue on their present basis, and that in his opinion, if continued, they might need to concentrate upon providing luxury features, such as private room care, etc.

When asked whether or not the recently-launched British Columbia plan should go on with its enrolment of members in view of the possibility of health insurance, I strongly urged that the plan should go on quite irrespective of proposed federal legislation. Even if the enabling legislation does pass the federal house in 1944, it might take some time for it to be adopted in the individual provinces. There would be still further delay in setting up the machinery, including the extensive regulations which would be required, and the voluntary plan might serve the public for some time before the provincial plan would actually be in operation. Any expenditures of underwriting would be repaid by that time, valuable actuarial information now lacking could be

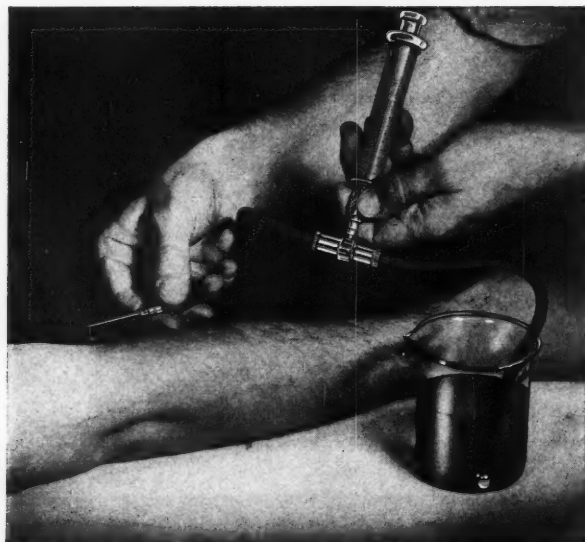
obtained, and executive personnel trained. Moreover, as one leading British Columbia administrator stated, and with which I fully agree, a successful British Columbia hospitalization plan might do much to influence the form in which health insurance might be developed there at a later time.—G.H.A.

**Radiological Technician  
Shortage in Barbados**

From information received there is a serious shortage of radiological technicians in the Barbados. The Barbados General Hospital serves not only the Barbados but also the colonies in the eastern group of the West Indies. This work is now seriously threatened by the lack of technical help. The situation is now so grave that the Governor, Sir Frank Stockdale, has made a personal appeal to Ottawa to find someone in Canada if at all possible.

Mr. A. Wood, Employment Service Division, Unemployment Insurance Commission, Ottawa, has directed this request to the attention of the Canadian Hospital Council.

**HIRSCH-ADAMS** MULTI-PURPOSE  
**AUTOMATIC BI-VALVE**



**FOR USE IN:** Transfusions, Intravenous Injections, Pooling of blood plasma, Infiltration, Aspiration, Artificial pneumothorax, Phlebotomy, Irrigations.

• Sidney Hirsch, M.D., New York—Annals of Surgery, February, 1943.

**T**HE HIRSCH-ADAMS Automatic Bi-Valve is an ingenious ball valve device originally designed for transfusion of citrated blood to infants and children. Here it permits the use of narrow gauge needles and cuts the time of transfusion over that required for the gravity feed methods. When the Automatic Bi-Valve is connected with a syringe, pulling out the syringe plunger automatically opens the inlet valve and closes the outlet valve; and conversely, pushing in the plunger automatically closes the inlet valve and opens the outlet valve. Arrows indicate the direction of flow.

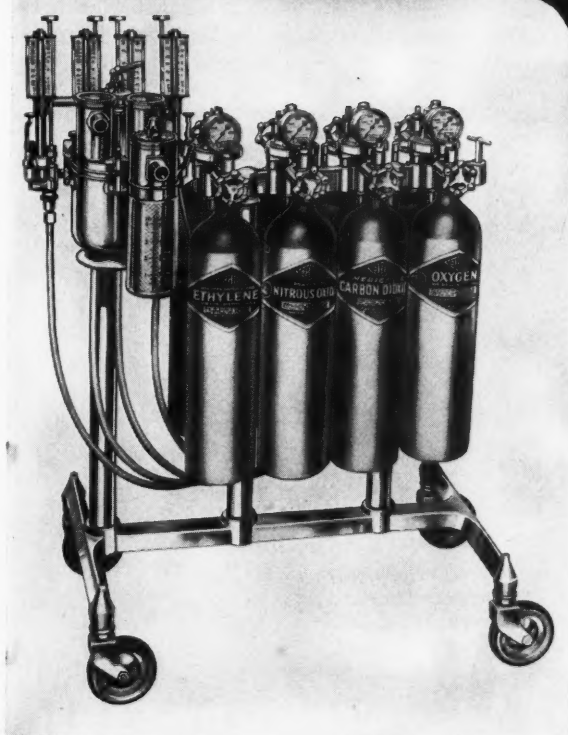
When the operation of the Valve is clearly understood, its wide range of utility will suggest itself to you. Standard accessories such as most doctors and hospitals already have are used: Luer syringes, nine inch lengths of thick wall clysis tubing, sinkers, Luer needle adapters and standard Luer needles of various gauges and lengths.

Order from your Surgical Dealer.

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44 EAST 23rd STREET, NEW YORK, N. Y.



**TIME  
TO LOOK  
*Both*  
WAYS**



**JANUARY**—a time when you are doubtless looking over the past year and making plans for the new. In these deliberations of yours, new equipment will probably receive your careful attention. We suggest you include in your plans a

**HEIDBRINK KINET-O-METER**

The Kinet-o-meter takes the uncertainty out of the administration of anesthesia—can be relied upon to handle any emergency—and enhances the technique of the anesthetist. It is also preferred for its simple, understandable, safe, economical operation, unusual flexibility, and sturdy construction.

The Kinet-o-meter brochure describes in detail the 4-gas, 3-gas, and 2-gas Heidbrink anesthesia apparatus and accessories. Write for a copy to aid you in equipment planning.



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## Control Board Rulings

### Soldiers' Dependents

Negotiations are still proceeding with respect to an agreement for the hospitalization of dependents between the hospitals and the Dependents' Board of Trustees. A "fifth draft" of a possible basis of agreement has been submitted to the Canadian Hospital Council and through that body to the various hospital associations and conferences. However, as certain essential points have not been included, no final agreement has yet been reached.

### Instant Dismissal

National Selective Service has written to the Canadian Hospital Council with respect to the procedure to be followed in the case of instant dismissal of employees.

"In cases of instant dismissal of male employees will you please use Separation Notice N.S.S. Form 120 (form previously used and now being used for female terminations). In

all other cases of termination of male employees use N.S.S. Form 208. *When using Form 208 mail all three copies to this office for approval. When using Form 120 hand the white copy to the employee at the time of dismissal.*

"In the section 'Dismissal for Cause', a check-mark should be inserted, but in the space 'If for other Cause, Specify' please give the reason for instant dismissal."

### Jelly Powders

During the past few weeks further correspondence has taken place respecting the jelly powder situation. The desirability of taking steps to obtain new sources of supply of gelatine has been impressed upon the Government and emphasis has been laid upon the importance of jelly powder in hospital dietaries.

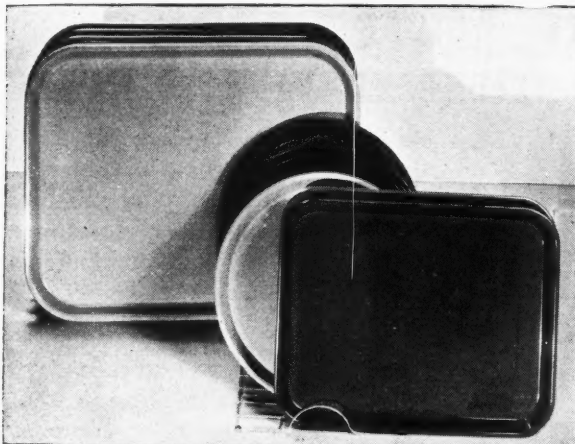
Last month Mr. Clive Planta, secretary of the Foods Administration, W.P. & T.B., requested the

Canadian Hospital Council to obtain a general idea of the amount of jelly powder used in hospitals in a normal year. A spot study of the consumption in a number of hospitals was made. This suggested that the average amount per patient meal in a normal year was .050 ounces. Calculated on a basis of patient days in 1941 this would work out to approximately 210,000 pounds for all Canadian hospitals. At the same time inquiry was made of a number of wholesale firms supplying hospitals. Although all firms have not replied, the replies received indicated sales of approximately 165,000 pounds for the same year. The correct figure is probably about midway between these two approximations.

Answers received would indicate that present-day shipments of jelly powders to hospitals are short from 30 to 60 per cent of hospital requirements.

The time is long past when hospitals can be used as hotels for people of large incomes and little ills.—  
*E. A. Horton.*

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\* Hospitals only

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## Wholesome — Delicious — Flavourful

These are the enthusiastic expressions of praise used by dietitians in describing Gibbons Quickset Jelly Powders and Desserts. Easily prepared in 20 minutes to half an hour, Gibbons "a Cent a Serving" Jellies and Puddings are reserved, as always, for hospital and institutional use only. Refer to this list for your favourite dessert.

### Jelly Powders

Wild Cherry, Lemon, Orange, Raspberry,  
Strawberry, Lime

### Lemon Filling Gingerbread Mix

### 3-way Custard Powder

Vanilla

### Pudding Powders

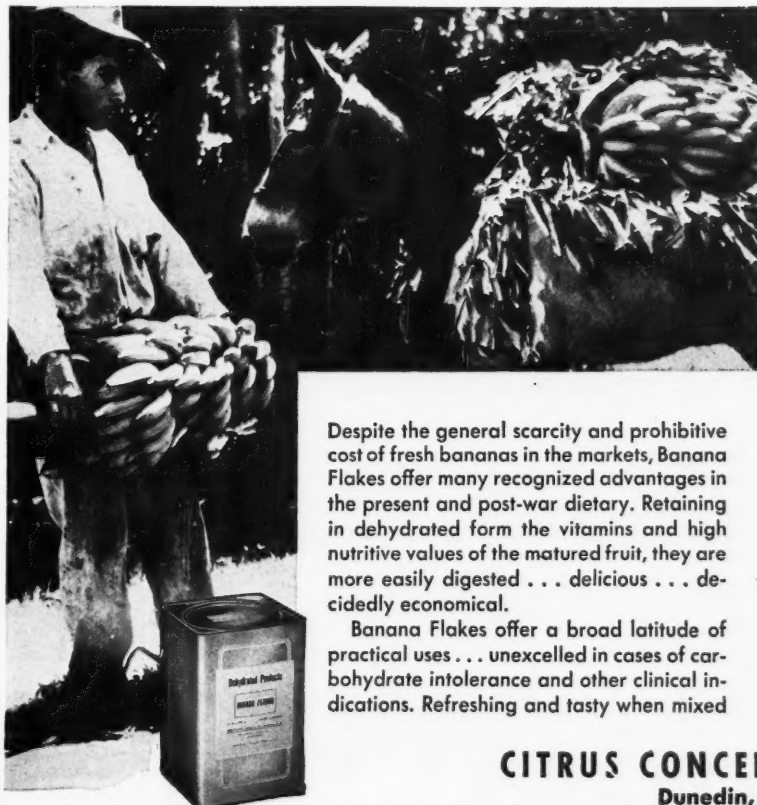
Chocolate, Caramel, Butterscotch,

Assort your order  
with  
some of each,  
rather  
than all of one.

**GIBBONS**  
**QUICKSET DESSERTS**  
TORONTO CANADA

This assures equitable  
distribution  
of these  
sugar rationed  
products.

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## Banana Flakes

for wartime America

DEHYDRATED FROM THE  
WORLD'S FINEST TREE-RIPENED  
BRAZILIAN BANANAS

Despite the general scarcity and prohibitive cost of fresh bananas in the markets, Banana Flakes offer many recognized advantages in the present and post-war dietary. Retaining in dehydrated form the vitamins and high nutritive values of the matured fruit, they are more easily digested . . . delicious . . . decidedly economical.

Banana Flakes offer a broad latitude of practical uses . . . unexcelled in cases of carbohydrate intolerance and other clinical indications. Refreshing and tasty when mixed

with milk as a beverage. Highly satisfactory for cooking and ice creams when the true banana flavor is desired.

Banana Flakes will store indefinitely without refrigeration if container is firmly closed. Temperature changes will not affect quality or consistency of the product. Economical? . . . each pound of Banana Flakes is the equivalent of 80 tree-ripened bananas,—at a cost surprisingly nominal.

ORDER TODAY or request our representative to call for demonstration

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## Pensions Department Confident Adequate Beds Available

The Federal department of Pensions now has sufficient beds to meet any emergency that might arise out of a sudden heavy flow of casualties from overseas, according to a department official in an interview with the Canadian Press on December 29th.

"The pre-war bed space in Government-owned hospitals will be increased tenfold before the end of the war," he said. "We can't foresee what is going to happen to Canadians on the battlefields, so we have drawn up plans that are ready for use should an emergency arise in the handling of casualties."

In preparation for such an emergency the department has:

1. Built new hospitals, enlarged others and increased the number of beds in its hospitals from 2,800 to 7,200.
2. Drawn up plans for further enlargement of its hospitals to increase the number of beds to 13,000 or more.

3. Arranged with general hospitals throughout the country to help in the handling of ailing servicemen in centres where the department has no hospital of its own.

4. Arranged to use some of the 14,500 beds in Defence Department establishments across the country, should the need arise.

5. Marked off buildings which could be used as hospitals in an emergency.

When this war broke out the department had approximately 2,800 beds. With the building of new hospitals and the enlarging of others the normal bed capacity has been increased to 7,200. That normal capacity probably will be doubled before the end of the war and could be redoubled in an emergency.

By next April 1st, the official said, an additional 980 beds will be available in hospital space now under construction in London, Ont., Toronto and Saint John. Contracts have been let for the building of

space for another 935 in Edmonton, Winnipeg and Ste. Anne de Bellevue, Que.

In addition, the department is preparing plans for the setting up of an additional 2,777 beds in Vancouver, Regina, Toronto, Montreal, Halifax, Saint John and London, and also contemplates the provision of 1,400 beds in five health and occupational centres.

"We anticipate that by 1945 some 27,000 beds will be available for the care of wounded and sick members and ex-members of the forces in the department's hospitals and in the hospitals of defence establishments," he said.

"In an emergency, space could be provided for 30,000 beds, more than ten times as many as could be provided for at the outbreak of war.

"Having this in mind, and also the Pensions Department contracts with general hospitals throughout the country, it is believed that any emergency can be satisfactorily met and that the post-war requirements of discharged personnel will be fully provided for."

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Darnell Dependability assures savings, service, safety, speed. A caster or wheel for every use.

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# CLINITEST

THE NEW 1 MINUTE TABLET TEST FOR URINE-SUGAR

*Active reagents  
all contained in  
a single tablet*



CLINITEST in the OFFICE



CLINITEST in the LABORATORY

*Standard  
Fool-proof  
Technique*



CLINITEST in the HOME

The invariable reaction to a demonstration of Clinitest is one of wonder that so *dependable* a test method could, at the same time, be so *simple* and so *speedy*. Naturally this has been reflected in a rapidly increasing demand for Clinitest Sets.

## SOME ADVANTAGES WHICH OFFER SPECIAL APPEAL

No external heating required.

Standard fool-proof technique.

Active reagents in a single tablet.

Dependable . . . a copper reduction test.

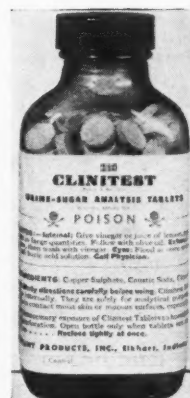
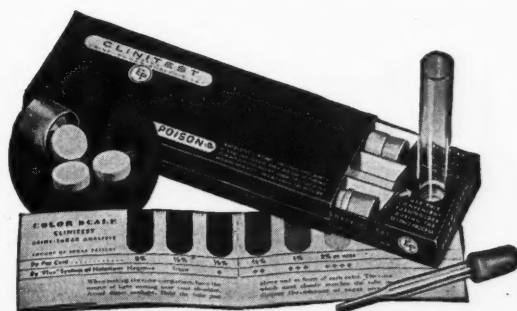
Indicates sugar at 0%, 1/4%, 1/2%, 3/4%, 1% and 2% plus.

## The Test involves 3 simple steps

1. 5 drops urine *plus* 10 drops water.
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3. Allow for reaction and compare with color scale.

*Write for full descriptive literature.*

*Available through your surgical supply house or prescription pharmacy.*



## FOR HOSPITAL USE

Clinitest for hospital use is available in bulk quantities of 1,000 and 3,000 tablets at special prices.

Orders for 1,000 are filled with 10 bottles of 100 tablets; while orders for 3,000 are filled with 12 bottles of 250 tablets.

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*Sole Canadian Distributors*

FRED. J. WHITLOW & CO., LTD., 187 DUFFERIN STREET, TORONTO

## Influenza

(Concluded from page 28)

Nursing Auxiliary for the training of V.A.D.'s included a course of lectures in Toronto. Throughout the province Sisters of service were found in many towns and cities to help those who were unable to help themselves. In Toronto and other cities the medical, hospital nursing and social services gave assistance to many thousands. From these cities auxiliary nurses were provided for outside points and, in addition, supplied medical assistance to communities where physicians were unable to cope with the situation.

The total number of deaths reported for the months of October, November and December, 1918, and January, 1919, in the Province of Ontario, was 8,705. It was estimated that there were at least 300,000 cases in the Province of Ontario. These undoubtedly were only the more severe cases.

The reports from the various military districts throughout Canada covering the period, September 19th to December 12th, 1918, indicated that

there were 61,063 troops in Canada. Among these there were reported 10,506 cases or 18.8 per cent of the whole. Of this number 505 were officers. Of those ill 2,208 suffered from bronchial pneumonia, or a rate of 19.2 per cent. There were 716 deaths. The incidence of the disease in military districts varied from 6.9 per cent to 42.4 per cent. Pulmonary complications in one district were 6.6 per cent and in another 80.4 per cent. Among the Canadian troops overseas there were 45,960 cases, of which 2,672 were officers and 43,288 other ranks. Of these 776 died.

### Further Extensions

During the period of maximum intensity—October, November and December—the disease spread along the lines of travel and invaded the most remote sections of the country. From ocean to ocean the story of Montreal and Toronto was repeated. People were found unprepared and were surprised into defensive activity. Every available agency was called into action to prevent the spread of

the disease but these were not of much avail.

In New Brunswick there were 1,394 deaths and in Saskatchewan 3,906 deaths. The death rate was lower in the western provinces of Alberta and British Columbia than in other parts of Canada.

To the people of the Labrador Coast and outlying parts of Canada influenza brought untold suffering. The existence of the disease in Labrador was unknown until the epidemic was over and only then were its ravages made evident. Villages were exterminated. Without medical and nursing services the resources of the people were totally inadequate to meet the outbreak. In many cases those who recovered were too weak to bury the dead and it was found that in some cases dogs had fed upon the bodies. When relief finally came it was generally too late and nothing could be done but bury the dead.

The total number of deaths in Canada was 30,000. The epidemic continued to prevail with diminished severity during the years 1919, 1920 and 1921.

All the goodness of  
home-cooked soups—

**SIMMER AND SERVE**

**Packed in Industrial Size**

**for Hospital Use**

### ● Make ONE serving or a hundred-and-one.

Here's a soup that hospitals everywhere are now serving daily. Stafford's Soups take but a few minutes to serve. Expert dietitians have already prepared them in spotless kitchens. All the vital energy-giving foods are preserved in Stafford's Soups . . . rich, satisfying bowls of goodness to tempt appetites and help give new strength to patients.

Simply add water and simmer—a real contribution to help solve the shortage of kitchen help these days.



**STAFFORD'S  
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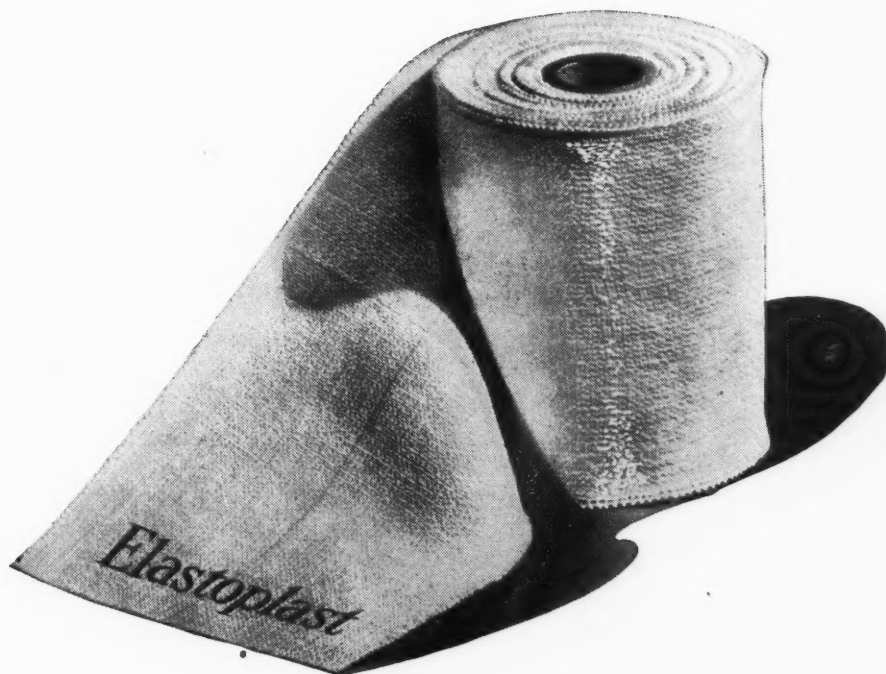
It is real economy to serve Stafford's Soups because a little of it goes so far . . . you can make up any quantity you wish, yes, even one serving at a time. The 5-gallon unit makes 5 gallons of soup. Choose from six delicious flavors, one for each week day. Order from your Stafford representative.

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# 'Elastoplast'

and dressings economy



An undisturbed occlusive elastic adhesive dressing is favoured in modern surgery, because it protects the forming granulations.

Such a dressing also entails a considerable saving in cost, because it obviates the need for frequently changed dress-

ings. 'Elastoplast', the modern surgical dressing, effects occlusion, with economy in cost as well as in doctors' and nurses' time. 'Elastoplast' has become the recognized surgical dressing in hospitals and in general practice everywhere.

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***Made in England by T. J. Smith & Nephew Ltd., Hull***

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### Hospitals in Britain

(Concluded from page 42)

of facts which the student must try to remember. We are seeking to foster a habit of mind, a way of looking at things, so that he sees all disease in a new light, and knows the soil from which it springs." The College desires such an attitude of mind that whenever a student sees a sick man "he will not only prescribe for his illness, but will ask himself whether there is anything wrong with his way of life, whether fatigue, overwork, monotony, under-nutrition, bad housing or domestic worry is affecting his health". Applying the same line of thought to the report on psychology the President gave a remarkable example of attention to the mental condition at one hospital. If a man, for example, is taken to it with a broken leg "the hospital telephones to his employer saying that he will be fit for work in such and such a time and asks if his place will be kept open for him. The employer says 'yes' and the man is told at once. His mind is at peace and since this has been done there

have been no cases of traumatic neurasthenia at the hospital". Inspired by such a leader there is every hope that the medical profession will respond to the layman's desire to live a healthy life and acquire the necessary knowledge to maintain him in it.

### Book Reviews

**FIELD CARE AND TRANSPORTATION OF THE INJURED.** \* Published by the Medical Division, U.S. Office of the Civilian Defence Washington, D.C., O.C.D. publication 2215. 1943.

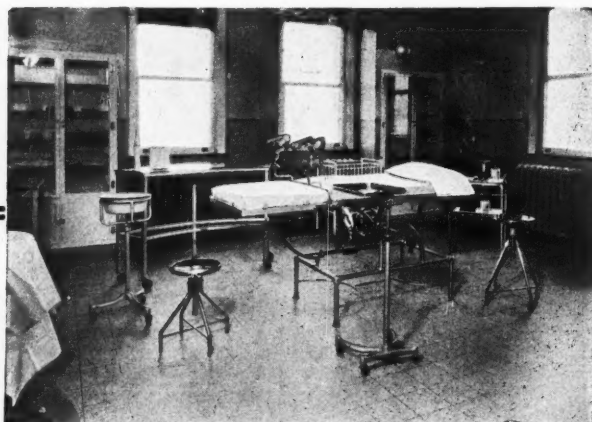
This very practical manual is intended for the advanced training of rescue workers, ambulance drivers,

stretcher bearers and others who have the responsibility of caring for the injured before they are seen by a physician, or are taken to hospital. In the preparation of this manual the U.S. Office of Civilian Defence was able to profit by the British and other air-raid experience, and acknowledgement is made for material derived from A.R.P. Handbook No. 10, issued by the British Ministry of Home Security and Health. The manual contains chapters on civilian defence, or emergency field care and on the transportation of the injured. The illustrations are good and the text is very practical. While written essentially from the viewpoint of wartime needs, the manual contains information of considerable value for peacetime care and transportation of the injured.

### Price Trends

(On basis 1926 = 100)

	Yearly Average 1942	Nov. 1942	Oct. 1943	Nov. 1943
<b>Building and Construction</b>				
Material .....	115.2	116.5	123.7	126.1
<b>Consumers' Goods</b>				
(Wholesale) .....	95.6	96.7	97.3	97.4
(On basis 1935-1939=100)				
<b>Cost of Living</b> .....	117.0	118.6	119.3	119.4



### STAN-STEEL HOSPITAL EQUIPMENT

IS . . . EASILY MOVED because of the use of smooth-running wheels on all rolling equipment.

AND . . . SILENT due to rubber-tired casters.

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### IDEAL for EVERY MEDICAL INSTITUTION

Stan-Steel Hospital Equipment is stronger because of welded steel construction which also adds symmetrical neatness, eliminates loosening and rattling. And the use of metal tubing wherever possible ensures a lighter, easier-to-move piece of furniture minus dust and germ-concealing crevices! Our catalogue illustrates over 200 items. A goodly number available for immediate shipment. Write us . . . we'll gladly answer enquiries.

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*Hospital*

**EQUIPMENT**

*Announcing . . .*

**Our Appointment as Sole  
Canadian Distributors of**

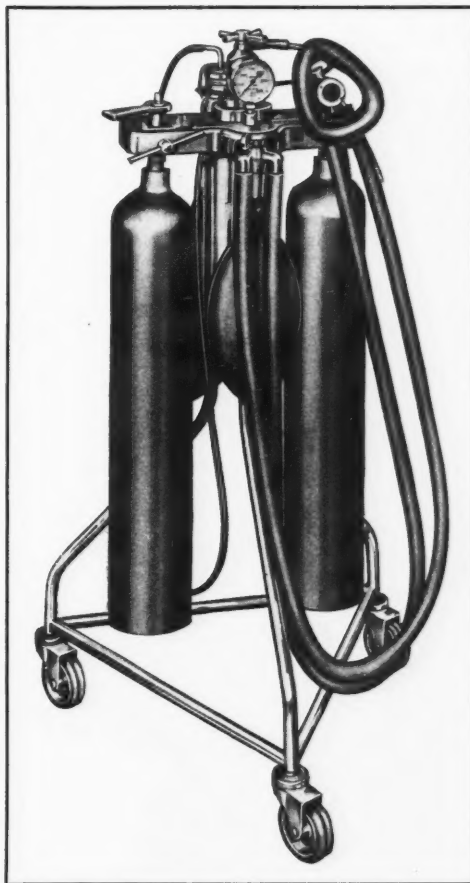
**THE  
EMERSON  
RESUSCITATOR**

**RESUSCITATION**—The Emerson Resuscitator is an automatic, self-adjusting breathing machine for use in all cases where natural respiration has failed, causing asphyxia. It is equally effective in resuscitation of the new-born and in the treatment of respiratory failure from shock, anesthetic accident, or post-operative collapse.

**ASPIRATION**—In addition to resuscitation, the Emerson Resuscitator - Aspirator - Inhalator combination may also be used for the aspiration of froth, mucous, or other secretions from the patient's throat.

**INHALATION**—It can also be used for the administering of oxygen therapy, employing oxygen carbon dioxide or helium mixtures.

**Manufactured by  
J. H. EMERSON CO.  
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***One Machine—Three Uses—Simple Operation***

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LIMITED**

PHARMACEUTICALS, SURGICAL INSTRUMENTS, PHYSICIANS, HOSPITAL  
and LABORATORY SUPPLIES

TORONTO - MONTREAL - WINNIPEG - CALGARY

**Epidemics**  
(Concluded from page 34)

**Resolutions**

The following resolution indicates the essence of the decisions:

"WHEREAS this Conference of the Canadian Medical Association Committee on Epidemics is fully conscious of the fact that the exigency of wartime living conditions, of travel, and habits of the people is conducive to the occurrence of epidemics of ravaging diseases, and these epidemics are usually of a severe type and of wide geographical distribution:

AND WHEREAS epidemic disease of a serious nature commonly follows in the wake of wars:

AND WHEREAS in a time of such national calamity the huge extra burden falling upon our Departments of Health can be borne only with the full support of voluntary effort on the part of our citizens:

AND WHEREAS this Conference has heard full and free discussion and given mature consideration to all pertinent facts relating to existing and possible circumstances:

NOW, THEREFORE, BE IT RESOLVED:

- (1) That we urgently recommend the organization NOW of all our personnel and resources to assist the Health Authorities in order that we may be prepared beforehand to cope with any such National Emergency which might threaten us."

Other resolutions recommended:

- (2) that permission be sought for the use if necessary of medical personnel in the Armed Forces for the care of civilians and that they be permitted to give such service legally if in a province other than that in which they are licensed;
- (3) that the "Suggestions for Provincial Organization" be approved;
- (4) that a special study be made of the problem of caring for women who are pregnant, a group that suffered heavily in the last epidemic;
- (5) that a wider use of approved immunizing measures for certain communicable diseases be urged; and
- (6) that the one laboratory in Canada equipped to study virus diseases (Connaught Laboratory, University of Toronto) be supplemented by similar facilities elsewhere to permit more extensive study of virus diseases. (See Editorial)

**Miss Wilson Resigns  
from Moncton Hospital**

Miss Ruth C. Wilson, for a number of years connected with The Moncton Hospital as secretary of the Board of Directors and an official in the hospital's business office, has resigned in order to devote her full time to the Maritime Plan for Hospital Care, of which she is Executive Director. The Plan is expanding rapidly under her able guidance, and has recently taken over additional office space.

Miss Wilson has been made a director of The Moncton Hospital.

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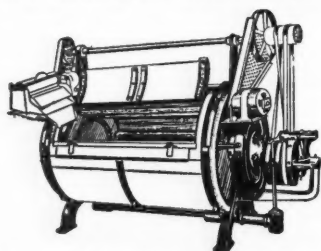
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